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The Illinois State Medical Society



Index to Volume 117

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Theodore R. Van Dellen, M.D.

Business Manager and Managing Editor
Mr. L. E. Malley

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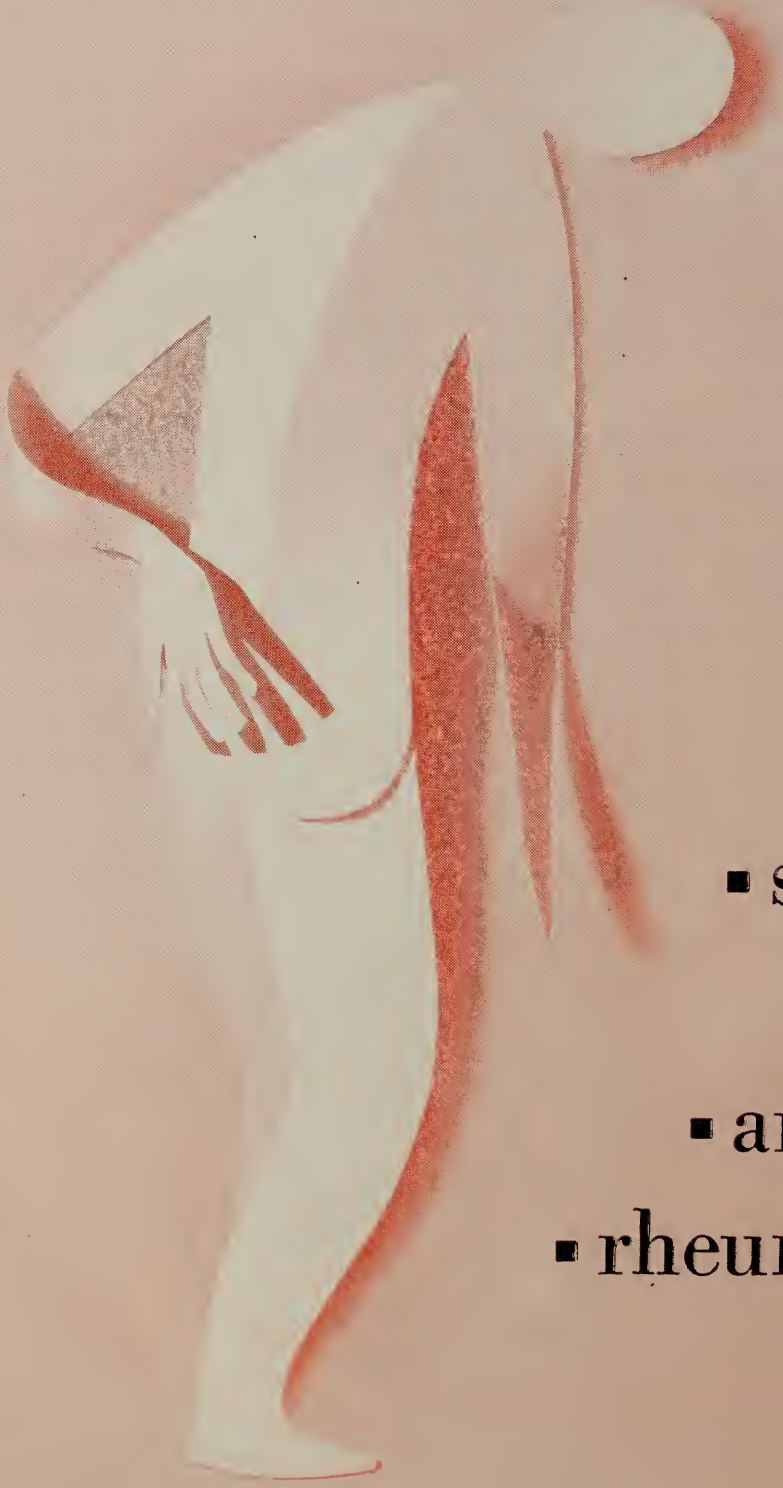
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in the low back syndrome



- sprains
- strains
- arthritis
- rheumatism

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Treatment of Tinea with Fulvicin (Griseofulvin)

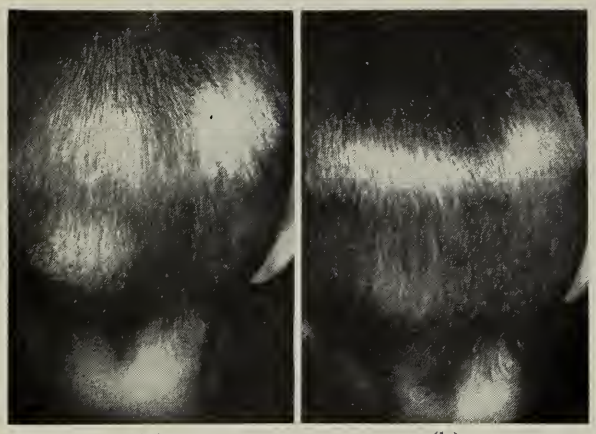
M. Murray Nierman, M.D.,* Calumet City, David M. Cohen, M.D.** and Milton Golden, M.S.,*** Chicago

Clinical background: The first reports of the use of oral griseofulvin in man, by Riehl[1] in Austria, Williams, Marten, and Sarkany[2] in England, and Blank and Roth[3] in America, reversed all previous concepts about the treatment and prognosis of superficial fungal infections. In the past, it had been necessary to attempt to penetrate the resistant keratinized layer of the skin with topical medication. This procedure invariably was difficult and frequently futile. Patients with histories of fungal disease of 10 or 20 years' duration were by no means rare. With the advent of the "wonder drug of dermatology"[4] that attacked fungi from within, it became possible to eradicate most mycotic infections of the scalp, nails, or glabrous skin within weeks or months.

From these and other[5,6,7,8] preliminary clinical studies, including our own,[9] it is possible to make the following generalizations about the effect of griseofulvin in dermatomycoses: In divided doses of one or two grams daily, griseofulvin produces significant improvement of tinea of the scalp or glabrous skin during the first or second week of therapy. After three to seven weeks, the clinical evidence of cure is confirmed by consistently negative laboratory results. In onychomycosis, a growth of healthy nail is observed after three to five weeks although four to six months or longer may be required before uninfected growth has replaced the parasitized nail completely. These results can be obtained in patients with extremely refractory tinea that has persisted for years and resisted all previous attempts at therapy. Tests among hundreds of patients have shown that griseofulvin has no significant effect on the urine or blood cells. Side effects, chiefly headache and gastrointestinal distress, occur occasionally during the early days of therapy but apparently there are no permanent untoward effects.

Griseofulvin is absorbed from the gastrointestinal tract and deposited in the dermal cells. As these cells approach the keratin surface, they retain sufficient amounts of the drug to prevent

*Clinical Instructor, Dept. of Dermatology, Chicago Medical School
**Professor of Dermatology, Chicago Medical School
***Bacteriologist, Mt. Sinai Hospital, Chicago



(a) (b)

Figure 1: A child with tinea capitis due to Microsporum audouini, of one year's duration, (a) before and (b) after one month of treatment with Fulvicin.

reproduction of fungi, which are thus confined to the previously infected layer. As this is shed, the involved area is replaced by nonparasitized, healthy tissue.

Scientific background: The intense clinical interest devoted to griseofulvin during the past year, which continues unabated, is in ironic contrast to the apathy displayed by clinicians during the two decades following its discovery. As Sulzberger and Baer point out, the many provocative references to griseofulvin in the literature of the basic sciences were ignored for years; ". . . eventually [griseofulvin was] discovered to be of use in medicine and receive [d] attention through reports at medical congresses and articles in medical journals."[10]

Isolation of griseofulvin as a metabolic product of Penicillium griseofulvum dierckx was announced by Oxford and his group in 1939.[11] At that time, promising new molds were assayed for antibacterial activity and those that showed none, such as griseofulvin, were discarded for clinical investigation. In 1947 Brian described a metabolite of another strain of penicillium that had the property of distorting the hyphae of fungi.[12] The hyphae, normally straight, became curled upon treatment with this agent, thereupon this became known as the curling factor. That year Grove and McGowan found that the Oxford and Brian substances were identical.[13] In 1951 Grove and associates solved the chemical structure of griseofulvin and showed that it could be obtained from four strains of penicillium.[14]

Griseofulvin was used only as a fungistatic agent in plants until, in 1958, Gentles reported on its successful use to eradicate induced tinea among laboratory animals;[15] fungistatic levels of the drug were found in the hair of treated animals.[16] Early in 1959 Martin confirmed the results of these animal studies[17] and griseofulvin* became available for experimental use in man.

METHODS

Composition of series: Fulvicin, in divided and gradually reduced doses of one or two grams daily, was used to treat 72 patients with tinea of the scalp, nails, or glabrous skin. (An addi-

*The drug is now available as Fulvicin from the Schering Corporation, Bloomfield, New Jersey. Our experimental supplies were provided by G. Kenneth Hawkins, M.D. of that company's Division of Clinical Research.



(a) (b) (c) (d)

Figure 2: This patient with onychomycosis due to Trichophyton rubrum, of ten years' duration, received two grams of Fulvicin daily for two weeks, one gram daily for six weeks, and 750, 500, and 250 mg. daily during each of the following three weeks. (a) Appearance of nails before therapy. (b) New growth was grossly observable at the proximal portion of the nails after one month of therapy. (c) At the conclusion of therapy, only a small portion of one nail was still parasitized. (d) After cessation of therapy improvement continued and, one month later, the growth of healthy nail was complete.



(a) (b) (c) (d)

Figure 3: A patient with tinea of the hands due to Trichophyton rubrum, of ten years' duration, (a) before therapy. (b) No improvement is observable on gross examination of the palm after two weeks of therapy. Because this area is hyperkeratinized, the new, nonparasitized dermal cells approach the surface slowly. (c) After five weeks of therapy, considerable improvement was observable. Only a few lesions remained on the center of the palm. (d) Cure was complete after seven weeks.

tional 12 patients who began but did not complete treatment have not been included in this report.) Several patients had been afflicted for years and none had responded satisfactorily to any previous attempts at therapy. Treatment was continued for a minimum of two weeks in tinea capitis or corporis to a maximum of 14 weeks in onychomycosis. All patients were examined at frequent intervals during therapy and were followed for at least one month after discontinuance (see table).

Laboratory studies: Skin scrapings, nail clippings, and hair from parasitized areas were prepared in potassium hydroxide and examined microscopically for hyphae and spores. The presence of fungi was confirmed in all patients. Cultures were made in Sabouraud's glucose agar medium before therapy was started and it was possible to identify the offending fungi by their characteristic patterns of growth. Microsporum audouini and canis; Trichophyton tonsurans, mentagrophytes, and rubrum; and Epidermophyton floccosum were recognized. These organisms are known to be vulnerable to Fulvicin. Cultures were repeated during and after therapy. Analyses of blood (erythrocyte and differential leucocyte counts) and urine were made periodically.

Criteria for cure: Negative laboratory tests (cultures and potassium hydroxide determinations) and clinical absence of infection, persisting for at least one month after cessation of treatment, indicated eradication of the saprophyte.

RESULTS

Effect on tinea: Fungal infections in all 72 patients responded rapidly to treatment. Therapy was continued until there was complete laboratory and clinical evidence of eradication. The patients with M. audouini infections of the scalp responded in an average of four weeks, and tineas of the smooth skin were cured in three to 10 weeks. In onychomycosis, therapy for three to four months prevented invasion of the newly growing nail by fungi from the previously infected portions (see table).

Recurrences: Two recurrences were observed among the 16 patients with tinea capitis due to M. audouini. In both instances, low doses of Fulvicin had been used because only minimal evidence of the disease had been observed before therapy. One patient, aged 8, appeared cured (cultures and Wood's light examinations negative) after three weeks of treatment with 500 mg. Fulvicin daily. His brother, aged 6, had had more extensive involvement and was given one gram daily. The first child had a recurrence one month after cessation of therapy and the sibling was reinfected. Permanent cure was achieved in both children with resumed dosage of one gram daily. The second recurrence was in a child, the youngest of four siblings with tinea capitis, who had presented a minimal case and received treatment for two weeks with 500 mg. daily. The other children had received higher amounts for longer periods of time. The youngest child



(a) (b)

Figure 4: A patient with tinea of the anogenital region, due to Trichophyton rubrum, of two years' duration. (a) The classical circinate lesions with elevated borders were observed before therapy. (b) Fulvicin relieved the condition in less than three weeks.

relapsed after one month, reinfecting another sibling; both were cured when therapy was resumed at one gram daily.

Side effects: The only untoward effect observed in this series was headache, sometimes rather severe, during the early days of administration of Fulvicin. There was no incidence of gastrointestinal distress or dermatoses induced by the drug although these effects have been reported to occur occasionally. Laboratory studies indicated that Fulvicin did not depress the bone marrow or adversely affect the blood chemistry in any patient.

COMMENT

Optimal dosage parameters: In superficial fungal infections, three weeks is the minimum period of therapy with Fulvicin, even if the disease may appear to be arrested much sooner, and one gram daily is the minimum starting dose. The daily dosage may be reduced gradually but administration should be continued for at least one week after apparent cure. If the starting dose is too low, or if administration is discontinued prematurely, the disease, although apparently cured, may recur when treatment is stopped.

Children with M. audouini infections of the scalp should receive one gram daily for three weeks. The suggested pediatric dose, 25 mg./Kg., may be too low and higher doses can be given safely.

After treatment of T. rubrum onychomycosis for at least 12 weeks, the nail will continue to grow normally although replacement with non-parasitized nail may not be complete at the time administration is discontinued.

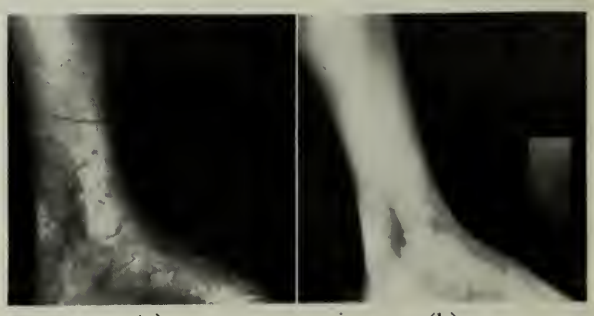
Patients with tinea pedis should be treated for approximately eight weeks. Since maceration and irritation from hyperhidrosis is characteristic, the excessive sweating also should receive attention and local treatment is recommended.

Indications: This drug is indicated only for the treatment of superficial fungal infections caused by species of Microsporum, Trichophyton, and Epidermophyton. It is essential, therefore, to establish the fungal nature of the disease and also to identify the infecting organism in culture. For example, fungal infections of the foot due to Monilia should be differentiated from those due to species responsive to Fulvicin since in the former, the drug is of no value and may exacerbate the infection. (We had used the drug experimentally in two patients with tinea versicolor (Malassezia furfur), in three patients with moniliasis, and in two patients with psoriasis; there was no response except in moniliasis, which worsened.)

Although Fulvicin is considered to be ineffective in all but the superficial mycoses, a group of investigators in Mexico reported several cases of nocardiosis (Nocardia brasiliensis) and several cases of sporotrichosis (Sporotrichum schenckii) in which a favorable response was obtained.[18] These authors point out that generalizations about the possible usefulness of Fulvicin in these indications would be premature, but their cases are provocative and perhaps further investigation will clarify the situation.

CONCLUSION

Fulvicin is predictably effective in tinea of the



(a) (b)

Figure 5: A patient with tinea of the ankle due to Trichophyton mentagrophytes, of three years' duration, (a) before therapy. (b) Cure occurred after three weeks of therapy.

Location of tinea	Causative organism	Number and ages	Duration of infection		Duration of treatment	
			range	mean	range	mean
scalp	M. audouini	16; 2-10 yrs.	3-12 months;	11 months	3-6 weeks;	4 weeks
scalp	T. tonsurans	1; 31 yrs.	10 years		12 weeks	
scalp, body	M. canis	1; 5 yrs.	3 weeks		2 weeks	
axillae	T. rubrum	1; 35 yrs.	1 year		4 weeks	
nails	T. rubrum	8; 29-61 yrs.	2-17 years;	9 years	12-14 weeks;	12 weeks
hands	T. mentagrophytes	1; 21 yrs.	2 years		3 weeks	
hands	T. rubrum	6; 18-53 yrs.	2-13 years;	8 years	6-10 weeks;	8 weeks
hands, nails	T. rubrum	3; 34-44 yrs.	3-15 years;	7 years	9-12 weeks;	11 weeks
hands, groin	T. rubrum	1; 24 yrs.	2 years		5 weeks	
hands, feet, nails	T. rubrum	3; 15-49 yrs.	3-10 years;	6 years	4-12 weeks;	8 weeks
hands, feet	T. mentagrophytes	5; 14-50 yrs.	1-10 years;	7 years	4-10 weeks;	7 weeks
hands, feet	T. rubrum	5; 15-53 yrs.	1-10 years;	5 years	6-8 weeks;	7 weeks
anogenital	T. rubrum	6; 15-51 yrs.	¾-5 years;	2 years	2½-8 weeks;	5 weeks
anogenital	E. floccosum	1; 35 yrs.	3 months		6 weeks	
feet, groin	T. mentagrophytes	1; 19 yrs.	3 years		6 weeks	
feet, groin	E. floccosum	1; 14 yrs.	3 months		3 weeks	
feet, nails	E. floccosum	1; 48 yrs.	3 years		3 weeks	
feet	T. mentagrophytes	9; 15-51 yrs.	½-10 years;	3 years	3-8 weeks;	5 weeks
feet	T. rubrum	2; 29-66 yrs.	3-5 years;	4 years	3-8 weeks;	5 weeks

scalp, nails, or glabrous skin caused by species of Microsporum, Trichophyton, or Epidermophyton if the drug is administered in sufficient dosage for an adequate length of time. Local therapy is unnecessary except for the hyperhidrosis associated with tinea pedis. Failures will occur if the drug is administered for nonfungal dermatoses or for deep-seated fungal disease.

SUMMARY

Tinea in 72 patients was treated successfully with Fulvicin (griseofulvin). The dosage usually was one or two grams daily, gradually reduced, for a minimum of two weeks in tinea capitis or corporis to a maximum of 14 weeks in onychomycosis. Headache was the only side effect; normal physiologic values were unaffected.

REFERENCES

1. Riehl, G.: Griseofulvin: an Orally Effective Antimycotic. Presented at a Meeting of the Austrian Dermatological Society, Vienna, (Nov. 27) 1958.
2. Williams, D. I.; Marten, R. H.; and Sarkany, I.: Oral Treatment of Ringworm with Griseofulvin, Lancet 2:1212-1213 (Dec. 6) 1958.
3. Blank, H., and Roth, F. J.: The Treatment of Dermatomycoses with Orally Administered Griseofulvin, A.M.A. Arch. Dermat. 79:259-266 (March) 1959.
4. Gaethe, G.: Griseofulvin—Twentieth Century Wonder Drug of Dermatology, J. Louisiana M. S. 111:302-305 (Aug.) 1959.
5. Reiss, F.: Treatment of Fungous Infections with Griseofulvin. Presented at a meeting of the New York Academy of Medicine, New York, (April 8) 1959.
6. Goldfarb, N. and Rosenthal, S. A.: Griseofulvin—Oral Antifungal Antibiotic, Current M. Digest 26:67-69 (April) 1959.
7. Robinson, H. M.; Robinson, R. C. V.; Bereston, E. S.; Manchey, L. L.; and Bell, F. K.: Griseofulvin, Clinical and Experimental Studies. Presented at a meeting of the American Dermatological Association, Atlantic City, (June 3) 1959.
8. Peterkin, G. A. G.: Griseofulvin in Ringworm, Brit. M. J. 1:1623 (June 27) 1959.
9. Nierman, M. M.: Treatment of Superficial Fungous Infections with Fulvicin (Griseofulvin), J. Indiana M. A. in press.
10. Sulzberger, M. B., and Baer, R. L.: Griseofulvin—An Oral Antibiotic for the Treatment of Many Common Fungous Infections of the Skin, Hair and Nails, Excerpta med. 13:145-149 (March) 1959.
11. Oxford, A. E.; Raistrick, H., and Simonart, P.: Studies in the Biochemistry of Micro-Organisms: Griseofulvin, $C_{17}H_{17}O_6Cl$, A Metabolic Product of Penicillium Griseofulvim Dierckx, Biochem. J. 33:240-248 (Part 1) 1939.
12. Brian, P. W.: Curling Factor, A Substance Causing Abnormal Development of Fungal Hyphae, Produced by Penicillium Janczewskii. Report of the Proceedings of the Fourth International Congress of Microbiology, 1947, pp. 153-154.
13. Grove, J. F. and McGowan, J. C.: Identity of Griseofulvin and Curling-Factor, Nature 160:574 (Oct. 25) 1947.
14. Grove, J. F.; Ismay, D.; Macmillan, J.; Mulholland, T. P. C.; and Thorald Rogers, M. A.: The Structure of Griseofulvin, Chem. & Ind. 11:219-220,1951.
15. Gentles, J. C.: Experimental Ringworm in Guinea pigs: Oral Treatment with Griseofulvin, Nature 182:476-477 (Aug. 16) 1958.
16. Gentles, J. C.; Barnes, M. J.; and Fantes, K. H.: Presence of Griseofulvin in Hair of Guinea Pigs after Oral Administration, Nature 183:256-257 (Jan. 24) 1959.
17. Martin, A. R.: The Systemic and Local Treatment of Experimental Dermatophytosis with Griseofulvin, J. Invest. Dermat. 32:525-528 (April) 1959.
18. Latapi, F.; Lavalle, P.; Novales, J.; and Ortiz, Y.: Griseofulvina en Micosis Cutaneas Profundas, Rev. Mex. Dermat. 3:34-41 (March) 1959.

Simple Rules in the Prescription of a Low-Fat Diet

Mrs. Dorothea F. Turner, Chicago

Reduction of the fat content of the American dietary from the present 40 to 45 per cent of the total calories to 20 to 30 per cent is being recommended in some situations. This often means more than a substantial reduction in fat. Simultaneous changes also are brought about in total calories, proteins, fatty acids, and other nutrients, depending upon the patient's present food habits. Success in changing food habits depends on the ability of the patient to understand the recommendations and his willingness to make the change. While these facts complicate the problem, they should be recognized to avoid deterioration in the over-all nutritional quality of the food.

A gross impression of the kind and extent of the changes which might occur can be gained from a picture of the average pattern of American dietaries. In 1955, a survey was made of a national sample of 6,000 families.[1] From these data, the average amount of fat available per person per day was estimated to be approximately 155 gm., or 44 per cent of the total calories. Approximately two-thirds of this fat was found to accompany foods usually thought of primarily as major sources of high quality protein, such as meat, poultry, fish, eggs, and milk products. The remaining fat came in the form of visible or separated fats and oils, such as butter, margarine, shortenings, oils, and salad dressings.

It would appear at first that the simplest way to reduce fat would be to eliminate separated fats and oils completely. This presents a possible hazard, however, in that complete elimination of certain items, such as cottonseed oil, soybean oil, or corn oil might mean loss of the major source of the polyunsaturated fatty acids (chiefly linoleic). If further research should indicate the value of retaining or adding polyunsaturated fatty acids to the diet, this would be a strong deterrent to the complete elimination of fats in this category.

Another obstacle arises from the practical problems involved in curtailing fats in food preparation. Fats and oils are commonly used in fried foods, gravies, baked products, and mixtures, such as stews, soups, salads, and desserts, as well as in baked, canned, and frozen commercial products. Obviously, new and acceptable methods of food preparation would be needed.

This leaves the large category of fats that occur in combination with proteins. Since the physician probably will wish to retain the sources of high quality protein, the problem becomes one of retaining protein rich foods while reducing fat in such items as meat, poultry, fish, eggs, and dairy products.

Meat, poultry, fish, and eggs: Fat on such meats as beef, lamb, and pork may account for substantial amounts of fat and high levels of saturated fatty acids. This can be reduced in part by close trimming and discarding fat at the table. In some cuts of meat, approximately 50 per cent of the fat in the meat may be removed in this way. Whether this measure is effective would depend upon the patient's customary habits in this respect.

It is possible that a more significant reduction in fat might be brought about in some cases by greater emphasis on meats naturally low in fat. This would mean more frequent use of chicken, turkey, and fish and less frequent use of beef, lamb, and pork. Not only would the absolute amount of fat be reduced in this way, but a relative increase in polyunsaturated fatty acids

Asst. Professor and Chief Medical Nutritionist, Dept. of Medicine, University of Chicago.

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the authors and do not necessarily represent the official view of that committee.

might be brought about since the fat of poultry and fish is higher in this respect.

Eggs have been considered by some to be an important source of fat. However, one egg contains only about the amount of fat contained in one ounce of meat, and is relatively higher in polyunsaturated fatty acids than beef, lamb, or pork.

Dairy products: It is possible to retain protein and remove fat to some extent by using skim milk instead of whole milk and cream. The new, instant, nonfat milks are gaining wide acceptance and may serve to bring about in some cases as much as a 10 to 15 per cent reduction in the total dietary. The selection of cheeses low in fat, such as cottage cheese or a specially prepared low-fat cheese-food, also may serve to effect a reduction in fat.

Jam, jelly, or honey could be used instead of butter as a spread for bread. Ordinary margarine would not serve this purpose since it is in the same category as butter in terms of fat and degree of saturation of fatty acids. However, several special margarines, processed to provide relatively high levels of polyunsaturated fatty acids are now on the market.

Nuts and baked goods: Although nuts are high in fat as well as protein, they are not ordinarily consumed in sufficient quantity to make a large contribution to the average U. S. dietary. Furthermore, they vary in linoleic acid content all the way from 10 per cent to more than 60 per cent of the total fatty acids with English walnuts at the highest level and other nuts 30 per cent or less.

Baked foods, either home baked or commercially prepared may contain nuts, milk, cream, eggs, and shortenings, making them high in fat and saturated fatty acids. However, a few products such as angel food cake (without frosting), Graham crackers, vanilla wafers, and arrowroot cookies are prepared without added fat. Gelatin and fruits also may be combined as desserts without adding fats.

Simple Rules for Prescribing Low-Fat Diets

The physician prescribing low fat diets is likely to be considering individuals of sedentary or moderately active habits in the age range of 30 to 50 years. For this purpose, he probably will find diets approximating 2,500 calories appropriate for maintaining normal weight for most men. For women of normal weight, diets approximating 2,000 calories might be satisfactory. For obese men or women, a diet approximating 1,500 calories could be expected to bring about loss of weight, and at this level of calories it would be possible to plan a diet that meets the recommended dietary allowances for other nutrients. Diets at these three levels are outlined below.

1,500 CALORIE DIET CONTAINING 80 GM. PROTEIN AND 30 GM. FAT[2]

While 30 gm. fat is only 20 per cent of the calories in the 1,500 calorie diet, this figure does not reflect the amount of endogenous fat being metabolized by the patient to meet the caloric deficit.

The following foods and food groups may be used in planning meals for one day. Numerous combinations of these foods are possible in making up meals. However, it is assumed that only these foods will be used; and that no fat or other products will be added in cooking.

Foods for one day	*Fat (gm.)*	*Calories*
One pint skim milk	0.5	174
One egg	5.5	77
Seven oz. lean meat, poultry, or fish	21.0*	367
Three slices bread or substitute†	1.5	240
Potato or substitute, 2 servings‡	1.0	220
Fruits and vegetables, 5 servings, including one citrus fruit and a dark green or yellow vegetable	1.0	240
Sugar, jelly, or honey, 3 tablespoons		180
	30.5	1,498

*This level of fat may be attained as follows: lean (all fat trimmed prior to preparation and all visible fat discarded at the table) beef, veal, and lamb only three times per week; chicken or turkey two times, and fish one or two times per week; liver 1 time in 2 weeks.

†One slice bread may be considered equal to ½ cup cooked cereal or ¾ cup of flake or puffed type cereal.

‡One-half cup white potato is equal to ¼ cup sweet potato, ½ cup cooked dried peas or beans, 2 Graham crackers, or 4 arrowroot cookies.

2,000 CALORIE DIET CONTAINING 80 GM. PROTEIN AND 50 GM. FAT

This level of calories may approximate the need for maintenance calories for most women of normal weight. Fifty grams of fat would contribute approximately 25 per cent of the total calories in contrast to the estimate of 44 per cent in the average American dietary. To accomplish these changes, the following additions could be made to the 1,500 calorie diet outlined above:

	Fat (gm.)	*Calories*
4 teaspoons fat or oil*	20.0	180
3 slices bread or equivalent	1.5	240
3 teaspoons sugar, jelly, or honey		60

*If it seems desirable to emphasize polyunsaturated fatty acids, such items as corn oil, safflower oil, soybean oil, and cottonseed oil will serve this purpose. Coconut oil, other palm oils, and cocoa fat (chocolate) are highly saturated and would not be suitable.

2,500 CALORIE DIET CONTAINING 85 GM. PROTEIN AND 70 GM. FAT

This level of calories may approximate the need for maintenance for most men of normal weight between moderate and sedentary activity. Seventy gm. of fat would contribute about 25 per cent of the total calories. These levels will permit the following additions to the 1,500 calorie diet.

	Fat (gm.)	*Calories*
8 teaspoons fat or oil*	40.0	360
6 slices bread or equivalent	3.0	480
2 tablespoons sugar, jelly, or honey		120

*See footnote for 2,000 calorie diet

Sources of Additional Information

For a further description of food plans, sample menu patterns, sample meals, and food preparation, reference may be made to the Handbook of Diet Therapy by Turner.[2] This reference also contains a compilation of fat, protein, cholesterol, and fatty acids in over 250 food items. These values may be used in developing particular percentages of fat calories, and various amounts of/or ratios between protein, fat, and fatty acids.

Numerous special purpose cookbooks have been published for use with low-fat diets. However, the suitability of any one recipe depends on the particular dietary prescription recommended by the physician. For this reason, the physician, dietitian, or nutritionist should aid in selecting appropriate recipes. Reviews of these cookbooks may be obtained from The American Dietetic Association, 620 North Michigan Ave., Chicago.

For a discussion of dietary fat consumption; the chemistry, metabolism, and nutritional role of food fats; possible relation to cardiovascular disease; and the needs for research, reference may be made to The Role of Dietary Fat in Human Health published by the National Academy of Sciences.[3]

REFERENCES

1. Household Food Consumption Survey, 1955. (U. S. Department of Agriculture, "Agricultural Research Service Reports," Nos. 1-10), 1957.
2. Turner, D. Handbook of Diet Therapy. 3rd ed. Chicago, University of Chicago Press, 1959.
3. Committee on Fats, The Role of Dietary Fat in Human Health (Food and Nutrition Board, National Academy of Sciences, National Research Council, Publication No. 575 (1958).

The Use and Abuse of General Anesthesia in Obstetrics

Arthur T. Shima, M.D., Oak Park

In the past few years, anesthesia for obstetrical procedures has become one of the most discussed problems. Pick up any journal dealing with obstetrics or anesthesia and you find a discussion on a technique procedure, or a newer agent for obstetrical analgesia or anesthesia. There are proponents of local, spinal, epidural, and caudal, as well as of general anesthesia with various agents and techniques.

Each shows that when a certain technique or agent is used, complications, morbidity, and mortality are lower than when another technique or agent is employed. The proponent of regional methods will point out that the outstanding benefits of utilization of regional technique in obstetrics is the absence of respiratory depression and other systemic effects deleterious to the fetus and mother. They mention the danger of vomiting, not only in patients who have just eaten, but in those who have had prolonged difficult labor, since in these, the hazard is the copious fluid vomitus resulting from retention of gastric secretions. On the other hand, many consider general anesthesia as indicated for obstetrical procedures because of the speed of induction, certainty of effect, ability to relax the uterus when necessary, and as the only way possible due to the temperament of the patient. They point to vasoparalysis with spinal anesthesia in gravid patients who already are suffering from interference with venous return and resultant decrease in cardiac output, causing sudden and recorded circulatory collapse. They also point to studies which have shown that under spinal anesthesia, a statistically significant depression of blood oxygenation occurs in the infant, both at birth and during the early neonatal period. This depression, however, is not significant clinically unless compounded with other more serious handicaps to the fetal respiratory physiology.

General anesthesia is the method by which most of the obstetrical deliveries are accomplished in this country at present. Mortality, by most statistical studies, is higher under general than under regional anesthesia. As the other causes of maternal mortality are conquered, anesthetic deaths assume an increasingly important role in reduction of maternal mortality since nearly all are preventable.

The fundamental causes of obstetrical mortality are derangements of the circulatory and the respiratory systems. These etiologic factors must be prevented or anticipated and treated prophylactically or promptly.

There may be hypoxia and acidosis due to anemia, hypotension, or interference with oxygen supply or carbon dioxide excretion as in the oversedated patient. In addition to factors such as pre-existing pulmonary disease that may be responsible for a reduction in the effective alveolar ventilation, general anesthesia adds the possibility of added respiratory derangements.

Obstruction to the airway is the most common difficulty and the most serious of all hazards associated with the administration of general anesthesia. Vomitus and possible regurgitation resulting in respiratory obstruction is by far the most important cause of anesthetic death in obstetrical patients. The asphyxia caused by vomiting and aspiration can be prevented if the obstetrician instructs patients to avoid eating after labor begins and if general anesthesia is not employed after the patient has eaten or has had a prolonged difficult labor, when retention of gastric secretion may have taken place. Another cause of respiratory derangement is the

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Clinical Assistant Professor, Anesthesia, University of Illinois College of Medicine; Director, Department of Anesthesia, West Suburban Hospital, Oak Park.

depression of the respiratory center which can be caused by any narcotic, sedative, or anesthetic drug.

The prevention and treatment of respiratory derangement is establishment of a clear airway and assisted or compensated respiration. Much has been accomplished to make general anesthesia safer and more physiological, by refinements in techniques and by the addition of agents that produce less nausea, vomiting, and derangement of the physiology. But the obstetrical patient has not derived as much benefit from the progress in anesthesia as has the surgical patient. Obstetrical anesthesia in some of the most advanced hospitals (advanced, that is, so far as surgical anesthesia service is concerned) consists of a quality of service that would not be tolerated in their surgical suites.

The use or abuse of general anesthesia in obstetrical procedures is dependent upon the degree of judgment and skill that goes into its choice. The anesthesic chosen must be tailored to the status and needs of the patient. This can be accomplished only by intelligent teamwork by members of the obstetrical team to the same degree as that now seen in the surgical team.

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Penicillin Resistant Pathogenic Staphylococci

L. S. Schaller; J. D. Schmidt; and R. W. Pumper, Ph.D.,* Chicago

A constant and serious problem faced by the physician today is infection and wound contamination by penicillin resistant strains of Staphylococcus aureus. We need to have positive knowledge of the frequency with which these organisms appear in the general population. The following project was carried out to determine the incidence of penicillin resistant pathogenic staphylococci in a surburban high school group.

Volunteer male students aged 14 to 16 from Lyons Township High School, were asked the following questions:

"Have you been in a hospital in the past two months?"

"Have you been in contact with anyone who has been in a hospital in the past two months?"

On the basis of negative answers to these questions, 50 students were selected. Specimens were taken by swabbing the tonsillar region and streaking each swab directly on a nutrient agar plate. Standard methods for obtaining isolated colonies were used. After 48 hours of incubation at 37 C., a loopful of each colony having gross staphylococcal morphology was transferred to a microscope slide and gram stained. Each isolate that proved to be a gram positive micrococcus was then subcultured on an agar slant. Following re-incubation at 37 C. each culture was again checked for gram positiveness and used in the following tests: Phenol-red-mannitol agar slants and tubes containing one ml. of a 1:10 dilution of human plasma (coagulase test) were inoculated with a loopful of each culture. The tubes were checked daily for mannitol fermentation and plasma clotting. A positive reaction to these tests, especially the coagulase test, is accepted as an indication of the pathogenicity of the staphylococcal organism.

Upon identification of the isolate as a pathogenic micrococcus, Petri plates were prepared for antibiotic testing by spreading each isolate

**Assistant Professor, Department of Microbiology University of Illinois College of Medicine.*

over the surface of a nutrient agar plate. A multiple antibiotic testing device, Multidisks® (Consolidated Laboratories, Chicago Heights, Illinois),[1] containing 9 different antibiotics, was placed on each of the plates which were then incubated at 37 C. At 24 and 48 hours the areas of inhibition or lack of inhibition of growth were noted, and the effectiveness of the antibiotic calculated.

Of the total 50 students tested, 68 per cent carried a species of staphylococcus but only 26 per cent carried a pathogenic species as shown by positive phenol-red-mannitol and coagulase tests. Of the pathogenic, or clinically significant strains, 23 per cent proved resistant to 1.5 units of penicillin. All strains were susceptible to 10 mcg. of Erythromycin® and/or tetracycline.

DISCUSSION

It is apparent that a large percentage of the male high school population in the area chosen carries a species of staphylococcus in their tonsillar region, but that only about one-fourth of these strains are pathogenic. In the concentration used, only Erythromycin and tetracycline were effective in inhibiting the growth of all pathogenic strains. The fact that 23 per cent of the pathogenic strains were resistant to penicillin indicates the prevalence of these organisms in a normal teen-age group. The over-all results are somewhat lower than those reported in other normal groups[2,3,4] but it is known that the prevalence of staphylococci varies with the season. These students also represented a select group. The necessity of performing laboratory antibiotic testing prior to therapeutic measures for staphylococcal infections is apparent, and if nonspecific therapy must be used, Erythromycin or tetracycline appears to be the antibiotic of choice.

SUMMARY

Of 50 teen-age, male, nonhospital-contact high school students tested for the presence of staphylococci in the tonsillar region, 26 per cent were shown to carry pathogenic and 42 per cent nonpathogenic species of this organism. Twenty-three per cent of the pathogenic strains were resistant to penicillin. All strains were sensitive to either Erythromycin or tetracyline.

It is a pleasure to acknowledge the assistance of Mrs. Priscilla Smith, Health Service Director, Lyons Township High School, for her cooperation in this project.

REFERENCES

1. Scherr, G. H.: A New Type of Impregnated Paper Disc for Determining Microbial Sensitivity to Antibiotics and Other Chemotherapeutic Agents, Antibiotics & Chemother. 4:1007-1010 (Sept.) 1954.
2. Griffith, R. S., et al.: Biological and Antibiotic Sensitivity Studies on Street Staphylococci, Antibiotics Annual, 370-379, 1957-1958.
3. Wise, R. I.; Cranny, C.; and Spink, W. W.: Epidemiologic Studies on Antibiotic Resistant Strains of Micrococcus Pyogenes, Am. J. Med. 20:176-184 (Feb.) 1956.
4. Dowling, H. F.; Lepper, M. H.; Jackson, G. G.: Clinical Significance of Antibiotic-Resistant Bacteria, J.A.M.A. 157:327-331 (Jan.) 1955.

A Case for Routine Operative Cholangiography

IRVING RUDMAN, M.D. AND MERLE L. OTTO, M.D., FRANKFORT

Recent surgical literature has devoted considerable space to discussion of operative cholangiography. Almost exclusively, interest has been concentrated on the question of whether utilization of this diagnostic method can help to reduce the number of common duct stones overlooked during cholecystectomy.

Many surgeons are convinced that the disadvantages of operative cholangiography outweigh its usefulness. Undoubtedly these men are influenced by their opinion that the risk of overlooking a common duct stone can be held to an acceptable minimum by conscientious assessment of the patient before surgery and careful study of the local situation at the operating table. It cannot be denied that obtaining a cholangiogram through the cystic duct can be time consuming and technically difficult. Air bubble artifacts can be bothersome. Sometimes the use of second choice anesthesic agents is required to avoid explosion hazards.

Perhaps as a consequence of these disadvantages, surprisingly little emphasis has been placed on the information readily obtainable by this technique whenever the gall bladder or common duct is opened.

Every surgeon is confronted, from time to time, by confusing or unexpected findings at surgery that testify to the unpredictable nature of biliary tract diseases. However, once surgery is in progress, arranging for cholangiography involves compromising the sterile field, the probability of unsatisfactory X-ray positioning, and hasty changes in anesthesia. Hence the surgeon who does not routinely plan to have cholangiography available is forced to deal occasionally with unpredictable findings that do not lend themselves to on the spot analysis as readily as does the question of whether a common duct stone is present.

From the Hedges Clinic, Frankfort

The authors have become convinced that operative cholangiography can be an indispensible aid at many times, notwithstanding its controversial value in identifying common duct stones. The basis for this opinion can best be illustrated by the following abbreviated case histories:

Case 1. The patient, a 41 year old female, became critically ill 24 hours after the onset of abdominal pain. She was known to have gallstones. Physical examination revealed obvious signs of diffuse peritonitis. The preoperative diagnosis was acute cholecystitis with perforation and bile peritonitis. At operation, extensive necrotizing pancreatitis was found. The gall bladder was not inflamed but contained numerous small stones. The common duct could not be examined adequately because of edema and fat necrosis. The pancreas was drained, the gall bladder evacuated of stones, and a cholecystostomy performed. A cholangiogram through the cholecystostomy tube was performed and revealed a patent cystic duct, a patent sphincter of Oddi, and no evidence of common duct stones. The operation was concluded.

Comment: Had cholangiography been unavailable, the surgeon would have been hard pressed to decide whether to risk a possibly unnecessary choledochotomy under extremely adverse circumstances or to chance leaving a potentially diseased common duct in a patient with acute pancreatitis.

Case 2. The patient, a 46 year old woman had undergone a cholecystectomy and common duct exploration recently, performed by another surgeon. The T tube had fallen out before postoperative cholangiography was done. A bile fistula had developed along the tract of the T tube. The preoperative diagnosis was residual common duct stone. The patient was explored and the common duct located with some difficulty. Fibrosis of surrounding tissue prevented safe dissection any distance from the fistula. The previous choledochotomy had been performed immediately distal to the cystic duct and this was the site of the fistula. The common duct was explored through the fistula opening and several small stones were removed from the distal end. The right hepatic duct was explored and irrigated. However the left hepatic duct could not be identified. An operative cholangiogram revealed that the exploration was being done through the right hepatic duct

just below an anomalous cystic duct origin and that the left hepatic duct was obstructed at its distal end by a stone. With this knowledge, the right hepatic duct opening was extended to the common duct and the left hepatic duct stone was removed. A second cholangiogram revealed the biliary tree was now patent.

Comment: In the absence of cholangiography, considerable time and difficulty would have been involved in clarifying this unusual situation. Conceivably, the left hepatic duct stone might again have been overlooked.

Case 3. The patient, a 70 year old woman, was operated upon with a preoperative diagnosis of chronic cholecystitis and cholelithiasis. Symptoms of this disease had been present for at least 30 years. At surgery, the common duct was found packed with stones. Following cholecystectomy and removal of many common duct stones, attempts were made to dilate the sphincter of Oddi. These were unsuccessful, even after duodenotomy. A cholangiogram revealed a lengthy, apparently inflammatory stricture that virtually obstructed the distal one centimeter of common duct. A choledochoduodenostomy was performed. Followup cholangiograms during the next two months failed to show any improvement in the stricture despite the T tube decompression during this interval.

Comment: Without X-ray demonstration of the stricture's unusual length, the surgeon probably would have elected to rely upon sphincterotomy and T tube drainage. This choice presumably would not have been adequate.

Case 4. The patient, a 50 year old man, was admitted to the hospital with a diagnosis of cholelithiasis and obstructive jaundice. Cholecystectomy was performed and numerous stones were removed from the common and both hepatic ducts. A cholangiogram revealed still another stone in the left hepatic duct. After repeated probing and irrigation, the stone was removed.

Comment: This stone, demonstrated by the cholangiogram, would certainly have been overlooked. It has been acceptable practice for many years to perform cholangiography on the ninth or tenth postoperative day, prior to removal of the T tube. This approach seems illogical when the same information can be obtained before the operation is completed.

Case 5. The patient, a 60 year old female, presented precisely the same findings as Case 4. However, the surgeon was unable to dislodge the residual impacted hepatic duct stone which had been identified by an operative cholangiogram. A special effort was made to dilate the sphincter of Oddi widely, as suggested by Cattell and others, in hopes that the stone might pass.

Comment: In this instance, it is not known whether the residual stone still lies within the biliary tree or has passed. However, the only means by which irretrievable hepatic duct stones can be managed is to provide a maximum egress diameter at the sphincter. Ordinarily sphincter dilatation beyond a #5 or #6 Bakes dilator is not employed without special indication. Cholangiography established the motive in this case.

Case 6. The patient, a 50 year old woman, had a preoperative diagnosis of cholelithiasis and obstructive jaundice. Surgery consisted of cholecystectomy and removal of several common duct stones. The sphincter of Oddi was dilated easily up to a No. 5 Bakes dilator. Cholangiography was not performed during the operation. On the tenth postoperative day, X-rays revealed narrowing of the lower end of the common duct which appeared to be inflammatory. Two months later the patient was re-explored because of progressive sphincter obstruction. Biopsy of the papilla of Vater revealed carcinoma. There were several metastases in the liver.

Comment: It is unrealistic to presume that the two month delay in diagnosis altered the outcome in this case. However, it is conceivable that operative cholangiograms can identify small papilla lesions that otherwise would be undetectable during common duct exploration. Such lesions, if noted postoperatively, might well be sufficiently vague in outline that six to eight possibly vital weeks of delay would ensue, as in this case, prior to re-exploration.

DISCUSSION

In the opinion of the authors, these case histories represented circumstances in which operative cholangiography provided information that was unobtainable otherwise. In each instance, X-ray data at least minimized the operating time needed to evaluate the situation; in several cases, cholangiogram prevented errors in diagnosis or judgment.

Other examples can be mentioned. It occasionally is difficult to avoid operating upon a case of idiopathic cholangiolitis or viral hepatitis in the mistaken belief that extra-hepatic obstruction exists. Considerable anesthesia and operating time can be saved, in the circumstances, by an operative cholangiogram. Without X-ray facilities at the operating table, there is general reluctance to withdraw without intensive and protracted common duct exploration.

Similarly, in cases of gall bladder agenesis, the cholangiogram can shorten considerably the fruitless search for this organ and can simultaneously help to evaluate the common duct.

When emergency surgery is performed because of progressive acute cholecystitis in the poor risk patient, it is helpful to be able to demonstrate

patency of the cystic duct so that cholecystostomy may be selected as a satisfactory alternative, if necessary. At the same time, the status of the common duct is defined.

SUMMARY

The authors have presented a small series of patients in which the availability and use of operative cholangiography were judged to have played a vital role in surgical management.

If cholangiography is employed whenever the gall bladder or common duct is opened, the results will be rewarding and will not be attended by the technical difficulties inherent in cystic duct cholangiography.

It is emphasized that this technique must be available routinely to exploit its full value in an area notorious for its unpredictable anatomy, complex pathology, and relative inaccessibility.

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Use and Abuse of Radioactive Material

Wm. J. Pickett, M.D., F.A.C.S., Chicago

A casual review of the literature will reveal some difference of opinion on the value and safety of I^{131}. The isotope itself does not differ greatly from those used for other purposes, such as P^{32} for circulation studies, S^{35} in wound healing, and K^{42} in the study of potassium exchange in infants. These are, for the most part, beta emitters and of different half-life.

It is quite well understood that the amount of thyroid uptake of the isotope will depend upon the iodine hunger of the thyroid cell. Unless there is cellular hyperplasia there will be no increase in uptake. As indicated below, there is no increased uptake in nodular goiters, carcinoma, or papillary carcinoma unless iodine deficiency also is present.

There has been some criticism about the use of I^{131} in nodular goiter in children. It is felt that this may result in later carcinoma, and some cases have been reported in which this seems to have occurred.

Hurxthal believes that radioactive iodine should be used if it is taken up, but biopsy and surgery should be done first.[1] Oschner feels that thyroid nodules should be removed and if a thyroid deficiency is present, it can be controlled by the proper use of thyroid extract.[2]

Crile and Wilson report a case of carcinoma of the thyroid in which myxedema was induced by treatment with I^{131}.[3] However, a low grade papillary carinoma was transformed into a highly undifferentiated, rapidly growing, autonomous cancer. However, in this case, existing metastases were well controlled.

The use of radioactive phosphorus and sulfur in wound healing has demonstrated a concentration of these elements in the wound area in measurable amounts. But in no case has this interfered with the cellular physiology of the healing process.

Christian and Talso studied exchangeable potassium in normal full term newborn infants by the oral administration of the isotope, K^{42}.[4] The urinary output for 24 hours was then studied with a scintillation counter. K^{42} has a

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half-life of 12 hours and is a beta and gamma emitter. However, the amount given per mc/kg. of body weight was well within accepted tolerances (SB+G=0.1/51.7=1.9mc/kg.).

Various diseases of the thyroid, such as struma lymphomatosa (Hashimoto's disease), invasive fibrous thyroiditis (Riedel's struma), and granulomatous thyroiditis (DeQuerain) do not show any increase in uptake. However, the author has observed improvement in the latter disease through external radiation.

The following listing shows the 24 hour I^{131} uptake in certain thyroid conditions:

Euthyroidism	15-40%
Hyperthyroidism	over 50%
Hypothyroidism	5-15%
Myxedema	0-5%
Euthyroid hypometabolism	N
Hyperthyroidism without hypermetabolism	H
Iodine deficiency goiter (colloid and nontoxic multinodular)	N or D
Diffuse exophthalmic goiter	H
Toxic nodular goiter	H or N
Struma lymphomatosa (Hashimoto's disease)	L-N
Acute thyroiditis	O or D
Invasive fibrous thyroiditis (Riedel's struma)	N or D
Granulomatous thyroiditis (subacute thyroiditis)	D or O
Irradiated thyroid (external radiation or radioiodine)	D or O
Cretinism	H or N
Neoplastic goiters	
Adenoma	N
Carcinoma	D or L-N

SUMMARY

It might be said that I^{131} is of some value in the differentiation of certain types of thyroid disease. It is of therapeutic value in the disease condition in which it is taken up by the gland, whether carcinoma is present or not. It might possibly be of danger in an occasional case wherein the isotope has stimulated the growth of an existing malignancy. It is not a dangerous drug to use.

REFERENCES

1. Hurxthal, Lewis M.: Nodular Goiter and Thyroid Cancer, New England J. Med. 258:457-465 (Mar. 6) 1958.
2. Ochnsner, A.: Carcinoma of the Thyroid, Rocky Mountain M. J. 55:43-49, 1958.
3. Crile, G., Jr., and Wilson, D. H.: Transformation of a Low Grade Papillary Carcinoma of the Thyroid to an Anaplastic Carcinoma after Treatment with Radio-Iodine, Surg., Gynec. & Obst. 108:357-360 (Mar.) 1959.
4. Christian, J., and Talso, P.: Exchangeable Potassium in Normal Full-Term Newborn Infants, Pediatrics 23:1 (Jan.)1959.
5. Magalotti, M.; Hummon, I.; and Hierschbiel, E.: The Effect of Disease and Drugs on the Twenty-Four Hour I^{131} Thyroid Uptake, Am. J. Radiol. (Jan.) 1959.

An Evaluation of an Antihistaminic Drug in Children

Gilbert Lanoff, M.D., Chicago

The desirability of administering a drug to children only once or twice a day instead of every three or four hours in liquid as well as tablet form, is well appreciated by both parents and patients. In this investigation an antihistaminic preparation, Rynatan® in a palatable vehicle or tablet form, was administered to 220 children between the ages of 4 months and 16 years, during a six month period.

The product is composed of prophenpyridamine, pyrilamine, together with phenylephrine as their tannate salts. Kile[1], Lawler and Limperis[2], Villanyi and Stillwater[3], Simon[4], and Steller[5], have previously evaluated this preparation in the suspension[1,2,3,4] or tabule form[1,3,5].

The double blind technique was used and the code was unknown to the physicians or personnel dispensing the drug. Three liquid preparations, labeled A, B, and C, were similar in color, texture, and taste. Two tablets of similar appearance, labeled A and B, were compared in this study.

All patients given these drugs had seasonal or perennial rhinitis. The preparations were given to the patients if they had allergic symptoms, and all patients were given the same medication during the period of this six month study.

Suspension A was given to all new patients the first week of the study, suspension B the second week, and suspension C the third week. However, once the patient received suspension A he was kept on it for the duration of the study. Children who preferred taking the tablet form were given the drug in that manner. Some mothers wished to give their 2 or 3 year old children the drug in tablet form since they felt that it was an easier method for them to dispense. (Table 1 and 2).

During the six month period that the preparations were given, the patients or parent reported to the physician each week on relief of symptoms and side effects. Clinical improvement was evaluated during this period.

Attending Allergist, Allergy Clinic of the Children's Memorial Hospital. *This study was aided by grants from Irwin, Neisler & Co., Decatur, Illinois.*

TABLE 1
PATIENTS' EVALUATION OF RYNATAN

	Excellent	Good	Fair	Poor
Suspension A	18	12	6	14
Suspension B	12	7	14	19
Suspension C	11	18	5	16
Tabules A	20	7	5	3
Tabules B	6	2	3	22

TABLE 2

DOSAGE TABLE

	Number of Patients	Dosage	Range in Hours of Relief noted By Patients	Average Number of Hours Relief for Patient	Length of Time on Drug
Suspension A	50	1 tsp. every 6 to 12 hrs.	2-10 hours	6 hours	6 months
Suspension B	52	1 tsp. every 6 to 12 hrs.	1- 7 hours	2 hours	6 months
Suspension C	50	1 tsp. every 6 to 12 hrs.	1- 6 hours	4 hours	6 months
Tabules A	35	1 tabule every 12 hours	4-14 hours	8 hours	6 months
Tabules B	33	1 tabule every 12 hours	1-10 hours	2 hours	6 months

Side effects of these preparations were not serious. Drowsiness was mild, except in two cases where tabules were administered (Table 3). In other instances it was difficult to ascertain whether the complaint was a true reaction or actually part of the symptom complex of the existing pathology. Poor taste was reported by three children in each of the groups taking the suspension. No such comments were referred to the tabules.

The results of this study failed to produce any clear-cut differences in therapeutic response between liquid Rynatan suspension A, B, or C (a suspension of nontannate antihistaminics without the Durabond principle). However, there was evidence of more prolonged relief of symptoms with suspension A as compared with the other two liquid preparations (Table 2). Suspensions B contained no active ingredients.

The results of the therapeutic response with the tablets showed not only a higher percentage of excellent and good results with tabule A (Rynatan) as shown in Table 2, but a marked difference in the average number of hours of relief of symptoms (Table 2).

In reviewing the over-all results, this study brought about the realization of the difficulties presented in the evaluation of any antihistaminic preparation used by young children, mainly because allergic symptoms vary at different times of the day, week, and month, and because children with allergic rhinitis become so accustomed to their running nose problems they cannot present an accurate report.

TABLE 3
RYNATAN SIDE REACTIONS

	Suspension			Tabules	
	A	B	C	A	B
Drowsiness	3	2	2	2	0
Hives	1	2	1	0	0
Itchiness	3	1	1	0	0
Irritability	1	2	1	1	1

Our conclusions, based on the more responsible older children, indicate that there is a clear-cut difference in the results of the group using the tabules; the duration of relief increased from two hours to eight hours with the Rynatan tabule.

SUMMARY

Rynatan, a Durabond process antihistaminic combination, was given to 220 children in a double blind study to show the results of therapy with sustained duration of activity, and to substantiate evidence of previously reported low toxicity, wide acceptance because of palatability, ease of administration, and value in the field of antihistaminic therapy.

REFERENCES

1. Kile, R. L.: Oral Treatment of Pruritic Dermatoses with a New Antihistaminic Compound, Antibiotic M. 5:578-81 (Sept.) 1958.
2. Lawler, C. G., and Limperis, N. M.: Long-Acting Liquid Antihistamine in Pediatrics, Clinical Med. 5: 1958.
3. Villanyi, L., and Stillwater, R. B.: A Clinical Evaluation of Rynatan, (in press) Eye, Ear, Nose & Throat Monthly.
4. Simon, D. L.: Long-Acting Oral Decongestant, Antihistaminic Drug for Pediatric Usage, (to be published).
5. Steller, R. E.: An Effective Symptomatic Treatment for Upper Respiratory Infections, (to be published).

The Position of the Mental Health Clinic in the Community

Mavis Ann Smith, M.S.S., Executive Director*
Nathaniel S. Apter, M.D., Psychiatric Consultant
Alice Budlong, M.S.S., Psychiatric Social Worker
Samuel Hutter, M.S., Clinical Psychologist
Saul M. Siegel, Ph.D., M.D., Clinical Psychologist

The establishment of mental health clinics in communities where other public and private psychiatric facilities are not readily available is one of the results of our growing awareness of the impact of emotional problems upon people at all social, cultural, and economic levels. For the most part, civic-minded people have assumed the major responsibility of gathering public support for the initiation of these clinics. Where such interest has been shown in Illinois, and with the consent of the local medical societies, the Illinois Department of Public Welfare has made substantial contributions to the development of these clinics and the training of their professional personnel. Once organized and established, with support from the local organizations such as the United Fund and Community Chest, the Illinois Department of Public Welfare nurtures and maintains their growth with additional funds.

The purposes of this report are twofold: to describe the position of the Mental Health Clinic in the community, and to summarize the functions of the professional personnel working in the clinic.

FUNCTIONS OF THE CLINIC

The central position of the clinic in the community is derived from its advisory functions to other agencies and its role as a distributing center for diagnosis and care of the emotionally ill. More specifically, the functions of the clinic are:

(1) The urgent needs of the community are supplied by the clinic as a way station to and from the state hospital. Various individuals, including physicians and agencies in the community, request the clinic to determine whether or not a patient requires state hospital care. If hospitalization is advisable, clinic personnel prepare both patient and relatives for hospital admission and frequently attend to the administrative details for hospitalization. After conditional discharge from the state hospital, the patient may be referred to the clinic for follow-up treatment. On the basis of the observations made by clinic personnel, the hospital superintendents and their staffs may then declare that the conditionally discharged patient can be discharged unconditionally.

(2) The clinic provides psychiatric and psychological diagnostic aid to the practitioners of medicine in the community. In this connection, diagnostic consultation followed by psychiatric treatment, where indicated and when desired, are undertaken in conjunction and collaboration with the referring physician.

(3) Persons with emotional problems who are known to local welfare agencies, including the Department of Public Welfare, Illinois Public Aid Commission, and the Community Chest Agencies also are accepted for diagnosis and tratement.

(4) The clinic co-operates with the Special Education Departments of the local schools and colleges. Educational disabilities of emotional origin and organic brain impairment are the mutual concern of the school, community, and clinic.

(5) The clinic also provides the local courts and probation officers with professional clinical

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**McLean County Mental Health Clinic, 1201 N. Franklin Avenue, Normal.*

opinions regarding the potential management of juvenile offenders.

(6) The clinic acts independently in relation to individuals in the community who refer themselves for psychiatric evaluation and treatment.

PROFESSIONAL PERSONNEL

A: Psychiatric Consultant

The McLean County Mental Health Center has engaged a number of practicing psychiatrists as consultants, particularly psychiatrists with teaching experience in the large training centers. These consultants help formulate over-all medical and psychiatric policies and procedures of the clinic. They supervise the psychotherapeutic efforts of the personnel and help correlate the social history and psychological data with the clinical findings for diagnostic and therapeutic purposes. The consultants conduct clinical interviews with patients so that the majority will be seen by a certified specialist in psychiatry. They also foster the professional development of the staff personnel through individual and group supervisory sessions in which therapeutic programs for the patients are planned.

B: Psychiatric Social Worker

The care of patients is co-ordinated by the three disciplines of psychiatric social work, psychology, and psychiatry. The psychiatric social worker in our Center has the first contact with the adult patient or with the parent referring a child. She helps them express their problems, what they have tried to do about it, and how failure to resolve the problems has affected the family. She evaluates the situation within the context of the culture of the community and of this particular family in it and makes initial judgments regarding the suitability of the clinic to the needs of the family and whether or not their problems can be handled by the staff. She refers them to other agencies when this is indicated or desirable. She interprets to them how the staff functions in diagnosis and treatment. She provides an initiating experience with one member of the clinic team.

All intake notes are reviewed by and are discussed with a psychiatric consultant when necessary. The executive director, a psychiatric social worker who does all intake interviews, and the consultant co-operate in planning the next step for the patient. Determining factors are medical status of the patient; the motivation and capacity of the patient to use the resources and services of the Center; and, the availability of personnel to provide the necessary services. The training, experience, and work load of each member of the professional staff, as well as the community demands upon the Center, are taken into consideration in planning a psychotherapeutic program.

The social worker also takes the family history. At our clinic, the person presenting himself for diagnostic study through an intake interview is interviewed twice before beginning work with the psychologist and psychiatrist. Attention is focused on the history of this person's emotional interactions with people in his environment. The worker discerns the patient's attitudes towards his family and associates. She may also serve as a therapist. Supervision is provided by one of the consultants. Patients are assigned in accordance with the training, skill, personality, and interest of the worker. For instance, in our Center, play therapy with young children is done by the executive director under regular supervision by a child psychiatrist.

Another psychiatric social worker is responsible for the planning for all conditionally discharged patients and their families. She schedules appointments for them with the adult psychiatrists. She may also treat them on a supportive level under supervision. The frequency of therapeutic interviews varies with each patient's needs and abilities to use the services of the Center.

C: Clinical Psychologist

The main activities of the clinical psychologist, diagnostic work and psychotherapy, are based upon a background of disciplined academic preparation, close and careful supervision by senior clinicians, and experience with a variety of clinical problems. In our Mental Health Center the clinical psychologist administers the diagnostic devices used for the evaluation of intelligence, as well as projective tests for assessing personality. Before seeing the patient, the psychologist reviews the Intake Interview and the Social History. He also conducts a short clinical interview to establish rapport and obtain any further pertinent information. He notes the responses to these questions, the predominant

attitudes, and signs of tension or anxiety. An intelligence test and a figure drawing test are administered during the first meeting. If indicated, a test for brain damage also is done. Not only are the responses to the standard intelligence test items noted, but also the discrepancies in performance. The second meeting is devoted to projective techniques such as the Rorschach Method of Personality Study and The Thematic Apperception Test. If these are inadequate to establish a definitive judgment, other projective tests such as the Make-A-Picture-Story Test may be utilized. When all tests are scored and the material collated, a report is dictated and is comprised of the basic clinical problem, the evaluation of intellectual abilities, an estimate of personality functioning, a formulation of the dynamic factors in the personality, and an overall judgment of the prognosis for treatment. In the event that the patient is assigned to the clinical psychologist, the psychotherapy conducted by him is supervised by the consulting psychiatrist.

THE CLINIC AND THE STATE HOSPITAL

The clinic's position between the community and the state hospital may be understood by considering its work in connection with conditionally discharged state hospital patients and their families. A psychiatric social worker carries the responsibilities for scheduling appointments with the doctors either for supportive psychotherapy jointly with a physician or under supervision. Mrs. A., for example, is a 40 year old farmer's wife with four children. She was brought to the clinic by a friend who knew of her previous hospitalization and absolute discharge from "...." State Hospital. She was encouraged to come to the center for revaluation. Psychiatric examination revealed the need for re-hospitalization. She and her husband were advised of this opinion and given a letter to the superintendent of the state hospital. When she was discharged from the hospital, Mrs. A. returned to the clinic for weekly or bi-weekly psychotherapeutic sessions with a social worker for about a year and a half. During this period she did not have to return to the hospital despite repeated recurrences of depressive reactions. She eventually became more aware of some of the factors precipitating her emotional difficulties, recognized early symptoms, and grew more confident of her capacities to meet them. Most important, however, she became more able to seek and use the help of her husband in the management of herself, the family, and their farm. She was eventually referred to the Division of Services for Crippled Children for advice regarding medical care for her eldest daughter. The medical social worker co-operated with the school social worker in providing case work services for the girl until our patient was able to establish a more satisfactory relationship with her child.

A second example was a 68 year old man with an agitated depressive reaction superimposed on cerebral arteriosclerosis who was brought to the clinic by his family. Three years ago, after he had relinquished his business to his eldest son, he had several periods of hospitalization, including six months at "——" State Hospital. He was taken home by members of his family because he was provocative and prone to getting himself injured. Mr. C's son, an anxious, preoccupied business man, now brings Mr. C. to each appointment. This may be their only meaningful contact. In the psychiatrist's office, the son assumes the role of the interviewer and looks to the doctor for approval. He questions his father, he reassures him that he is getting better, and that the medicine he is taking is "safe, the newest, and best of its kind." They speak in English but occasionally lapse into their foreign mother tongue. Mr. C. is particularly pleased with the physician for reactivating his son's interest in him and the reversal of father-son role. The clinical picture continues to be that of slowly progressive cerebral arteriosclerosis, but the depression and agitation are lessened. Motility, mannerisms, and facial expressions are increasingly flexible. Mr. C. is able to joke a little about his wish to feel young and is more interested in external events. This patient has been able to maintain himself as his family has become more comfortable with him; their sense of guilt and irritability have been dampened by providing a key member with a helping role in association with an authoritative person.

THE CLINIC AND THE COMMUNITY: SCHOOL AND CHURCH

This clinical summary depicts the position of the clinic in relation to the community at large, the public school system, the church and the family practitioner. A 31 year old housewife

with five children, the first of whom was born prior to her marriage, attributed her growing irritability, fatigue, crying spells, and suspiciousness of neighbors to an anemic condition. Without delving into the entire family situation, her physician, after a physical examination, recognized that many social and emotional actions were operating in the patient. He advised her and her husband to utilize the services of the clinic. She soon became aware that the guilt associated with premarital sexual experiences had isolated her from her friends and church. For fear of exposing these experiences, she had not consulted various community agencies which could have assisted in providing special training for her two mentally retarded children. The husband knew of her illegitimate pregnancy and had superficially accepted it but had not been able, by virtue of his latent hostile and resentful feelings, to assume responsibility for directing the care of his children. The various workers in the clinic combined their efforts to uncover the sources of guilt and resentment in both partners so they could avail themselves once more of the community resources. As a consequence of these therapeutic efforts the patient and her husband re-established ties with the past. They rejoined the church they had left, relinquished the isolated social position they had assumed for defensive purposes, and the children were helped significantly when their parents eventually felt free to discuss their educational problems with members of the school system.

The position of the clinic in relation to the internist and the state hospital is illustrated in the following example. Mrs. D., a 42 year old housewife who doted on her only son, developed nausea when he emancipated himself from her. She insisted that her husband take her from one physician to another in an effort to discover the organic origin of her symptoms. She permitted herself to undergo multiple physical and diagnostic examinations. As soon as she was told there were no abnormal findings, she and her husband would consult another physician. Finally, one physician suggested psychiatric evaluation. Both patient and her husband refused such a referral but consented to come to the clinic on condition that both would be examined. It soon became apparent that both members were holding on precariously to tenuously compensated personality structures. The patient dared not express her hostile revengeful feelings toward her impotent husband. He, in turn, made social demands on his wife to bolster his own fragile position. Uncovering therapy was contraindicated; neither wished to explore their emotional problems. The patient was provided with an opportunity for a supportive relationship while the husband's defensive position was respected. He was helped to understand that some of his demands on his wife were unrealistic. In this setting, a chlorpromazine derivative was effective in ameliorating the symptom and in re-establishing a new level of relationship between them. This management has delayed or even prevented decompensation into a paranoid state in one or both partners.

THE CLINIC AND THE BORDERLINE PATIENT

The work of the clinic differs from that of the private psychiatric practitioner or the large psychiatric hospital or training center. Our clinic population is fairly heavily weighted at both ends of the age range; geriatric and pediatric psychiatry play an important role. In between are a large group of "as if" characters, ambulatory schizophrenics and schizoid personalities. The majority use their continuing contacts with clinic therapists in a symbiotic and identificatory manner. They obtain sufficient support from what is most often a minimal contact to maintain themselves in the community. The "as if" characters live only in relation to another person with whom they identify. They present ego-distortions of high caliber and are entirely unable to find any sense of identity unless they are provided with a possibility of engaging in a relationship with the therapist.

Miss A. and Mrs. B. are examples. Miss A. is a 19 year old girl referred by a dermatologist because he felt that she was in need of psychiatric care and possibly hospitalization. He had treated her for a skin disorder which appeared after she had been placed on a tranquilizing drug prescribed by another physician. Miss A. is the eldest child of a professional couple who have moved frequently from city to city to obtain new and better positions. The patient felt constantly uprooted. Her only relationship, predominantly autistic, had been with a high school student. After their graduation she moved to this commu-

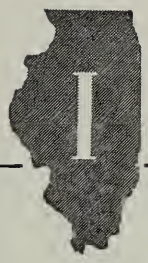
nity to be near him. She even sought employment where he worked and told the company personnel that she wished to be near him. She had eight jobs in three months. She identified with the woman therapist who saw her at intake and continues to see her weekly. Now the psychiatrist and the social worker see her together once a month so that she has some contact with an older man. She has now held one job for two months. She is maintaining herself financially, has accepted dates with other men, and behaves more realistically in all her other endeavors. She made some moves to join a church and the Y. W. C. A. after she asked for information about making other social contacts.

Mrs. B., a 36 year old woman, was referred to the Center by a friend who was a patient here, and whom she had idealized. She complained of inability to manage her children and herself, and to make a success of her marriage. She is afraid of her destructive impulses, especially in relation to her children. She had been in private psychotherapy before but terminated when she married Mr. B. She is an only child whose care was shifted from mother, to father, to grandmother when the parents were dissolving their marriage. She felt her father was "alcoholic but lovable" though he "took pleasure in tricking her" as a child. She said her mother and grandmother "hollered" to get their way. She does likewise, but now she wants to live in a way more "acceptable to worthwhile people." She has identified herself with a series of civic-minded women of greater education and social status and feels lost and rejected when these women withdraw from frequent contact with her. She is enraged by her husband's preoccupation with his job and hobby. She requests and resents his control over household arrangements. She was encouraged to come for weekly interviews but has not been able to keep them consistently. With discontinuous supportive therapy she has been functioning fairly well. During absences she becomes anxious and fights with her husband or children. She then telephones, expecting an immediate response from the therapist and resents the need to observe the regular clinic hours. The prognosis is not good. Our goal is to help her maintain herself in her home.

CONCLUSIONS

The general functions of the Mental Health Center as well as the general activities and functions of the various members of the team have been described. All of these activities are subsumed within the psychiatric team framework. The liaison functions of the Mental Health Center have been presented in some samples of our daily work. The Mental Health Center receives referrals from various agencies and is in turn responsible for referring clients to the various social agencies within the community. Patients are encouraged to utilize the facilities of these agencies. The Mental Health Center really is the general practitioner of psychiatry and as such is available for consultation to medical practitioners in the community.

CASE REPORTS



Major Muscle Rupture in Rheumatoid Arthritis

Melvin Van Woert, M.D. and Attallah Kappas, M.D., Chicago

This is a report of two patients with active rheumatoid arthritis in whom rupture of a portion of the triceps surae muscle group was observed. Muscle rupture in general appears to be an uncommon complication of this disease and such involvement of the calf muscle group in particular. It has been described only once previously.[1] Both patients reported here were women and muscle rupture occurred spontaneously, in contrast to the preponderance of men, in whom such ruptures generally of traumatic origin, are most frequently observed.

Case 1: In a 25 year old white woman, the initial manifestations of rheumatoid arthritis appeared in November 1955, during the fourth month of her first pregnancy. Within three weeks following delivery her arthritis became worse rapidly, involving in particular the small joints of the hands and feet, the knees, and the wrists. She was treated with bed rest, salicylates, and penicillin on the basis of a diagnosis made elsewhere of rheumatic fever. In January 1957, she was first seen in the outpatient department of the University of Chicago Clinics and the diagnosis of rheumatoid arthritis was established. She was mildly anemic, her ESR was 50 mm./hr. and her sheep cell agglutination test was positive in a titer of 1:1024. She received steroid therapy with dramatic relief of symptoms and some regression of the objective changes of her disease. This remission continued until August 1957, when recurrence of pain and swelling in the left knee and ankle joint was observed. At this time she was in the second month of her second pregnancy.

In September 1957, the patient reported the development of a mass in the calf muscles of her left leg. Several weeks previously she had become aware of an ache in the left calf on walking, and examination of this area by her husband revealed the presence of an orange sized tender mass in the area. This lump was tender to palpation for a week or so, but she was then generally asymptomatic save for the occasional sense of a heavy feeling in the area. There had never been any discoloration, rash, hemorrhage, or evidence of local inflammation. No history of trauma could be elicited and the only unusual exertion she had indulged in was a prolonged shopping tour shortly before the mass became evident. On examination of this area in the clinic a lump, approximately 6 cm. in diameter, was seen protruding from the posterior aspect of the left calf

From the Section of Arthritis, Department of Medicine, The University of Chicago; and the Argonne Cancer Research Hospital, operated by the University of Chicago for the United States Atomic Energy Commission.

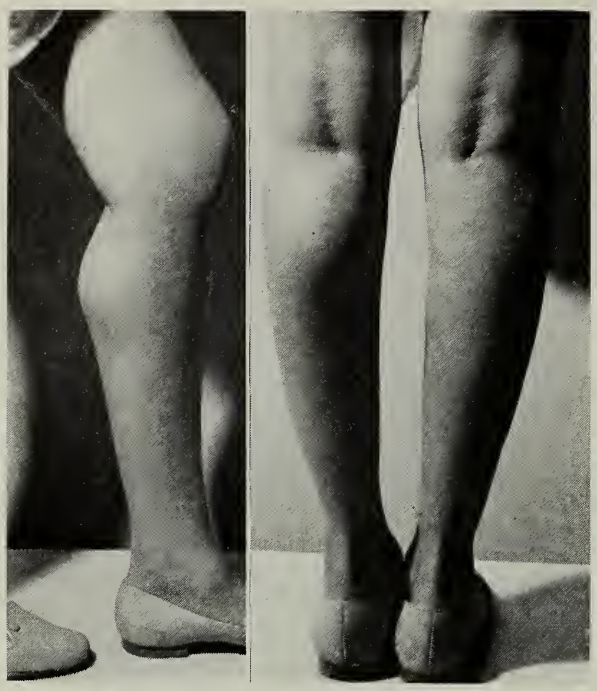


Figure 1. Calf muscle rupture, left leg. Case 1.

just below the popliteal fossa. It did not pulsate, nor was it unusually warm, cystic, or inflammatory in nature. It had the consistency of the gastrocnemius muscle below it and hardened when the calf muscles were made to contract. It was only slightly tender to palpation. X-ray examination of the area revealed no evidence of significant soft tissue or bone disease aside from the manifestations of rheumatoid arthritis in the adjacent knee joint. Biopsy was not permitted. Consultation with the orthopedic surgery service confirmed the opinion that this mass represented a rupture or herniation of a portion of the calf group of musculature. It was not possible on neurological examination to establish which of the triceps surae was involved. The Achilles reflex was retained and leg power was not impaired. The mass disappeared slowly in the following eight weeks without treatment and without residual disability. Photographs of the left leg, showing lateral and posterior views at the time the mass was first examined in the clinic, are shown in Figure 1.

Case 2: This 56 year old white woman had a history of recurrent active rheumatoid arthritis dating back to 1940. She first received steroid therapy in 1953 and this form of treatment continued in various forms and dosages to the present time. In addition, she had suffered from rheumatic heart disease with mitral stenosis and insufficiency for many years. Because of persistent angina and the appearance of signs of frank heart failure, thyroid ablation with radioactive iodine was achieved in 1954. Subsequently she was continued in a moderate hypothyroid state as determined clinically and by determinations of the basal metabolic rate. Her arthritis had been only mildly active in recent years although it was not possible to lower her steroid medication below 10 mg./day of prednisone without exacerbating her disease. In January 1958, she presented with complaints of the spontaneous development of a swelling in her left calf which was painful on walking. No antecedent history of trauma or unusual exertion could be elicited. On examination, a fusiform swelling could be seen in the upper portion of the left gastrocnemius. There was no heat, pulsation, fluctuancy, bruit, edema, discoloration, inflammation, or evidence of hemorrhage in the area. The swelling was tender to deep palpation, and hardened when the calf muscles were were made to contract. The Achilles reflex was equal bilaterally. X-ray of the area revealed no significant soft tissue or bony abnormalities. Except for slight pain on walking there was no physical impairment. No treatment was advised and in a subsequent clinic visit in May 1958, the mass had disappeared without leaving any residual disability. Photographs of the left leg, showing lateral and posterior views at the time the swelling was first examined clinically, are shown in Figure 2.



Figure 2. Calf muscle rupture, left leg. Case 2.

DISCUSSION

Major muscular rupture or herniation is an exceedingly uncommon complication of rheumatoid arthritis. The subject is dealt with only cursorily, or not at all, in the standard texts and reviews on this disease.[2-9] This seems surprising in view of the muscle pathology that has been described frequently in this disorder.[10-12] It seems credible to attribute these two muscular incidents more or less directly to some predisposing local consequence of the rheumatoid disease itself, for two reasons; 1) both subjects were women, and 2) the apparent absence in either case of any significant trauma or exertional episode. In contrast, muscular rupture in all other circumstances is observed predominantly in males and can in most instances be related to direct muscle trauma, abrupt excessive effort, or unusually directed force of exertion. The possible relation between steroid hormone therapy, hypothyroidism, the degree of rheumatoid activity in terms of possible severity (Case 1, onset during pregnancy) or chronicity (Case 2) and the development of muscular disruption in these patients remains speculative. The complication appears self-limited and requires no specific therapy.

SUMMARY

Two women with rheumatoid arthritis are reported, in whom spontaneous rupture of a portion of the calf group of muscles was observed. This complication itself is exceedingly rare and the physical impairment produced in these subjects was minimal and transient.

REFERENCES

1. Kersley, G. D.: Spontaneous Rupture of Muscle as a Complication of Rheumatoid Arthritis, Brit. M.J. 2:942, 1948.
2. Hollander, J.L.: Comroe's Arthritis and Allied Conditions. 5th ed. Philadelphia, Lea, 1953.
3. Traut, E. F.: Rheumatic Diseases — Diagnosis and Treatment. St. Louis, Mosby, 1952.
4. Kersley, G. D.: The Rheumatic Diseases. 3rd ed. New York, Grune, 1950.
5. Rheumatic Diseases. The American Rheumatism Association, Committee on Publications. Philadelphia, Saunders, 1952.
6. Copeman, W.S.C.: Textbook of the Rheumatic Diseases. 2nd ed. Edinburgh, Livingstone, 1955.
7. Robinson, W. D. et al.: Rheumatism and Arthritis. Ann. Int. Med. 39:487 & 758, 1953.
8. Robinson, W. D. et al.: Rheumatism and Arthritis. Ann. Int. Med. 45:831 & 1,060, 1956.
9. Short, C. L.; Bauer, W.; and Reynolds, W. E.: Rheumatoid Arthritis. A Definition of the Disease and a Clinical Description Based on a Numerical Study of 293 Patients and Controls, Cambridge, Harvard, 1957.
10. Desmarais, M. H. L.; Gibson, H. J.; and Kersley, G. D.: Muscle Histology in Rheumatic and Control Cases: A Study of 119 Biopsy Specimens, Ann. Rheumat. Dis. 7:132, 1948.
11. Kestler, O.C.: Histopathology of the Intrinsic Muscles of the Hand in Rheumatoid Arthritis, Ann., Rheumat. Dis. 8:42, 1949.
12. Horwitz, M.: Muscle Lesions in Rheumatoid Arthritis, Ann. Rheumat. Dis. 8:258, 1949.

Clinical-Surgical Conferences



Bleeding Peptic Ulcer

Department of Surgery
Cook County Hospital

Moderator:
Robert J. Freeark, M.D.
Director of Surgical Education
Cook County Hospital

Discussants:
Alfred A. Strauss, M.D.
Senior Attending Surgeon, Louis Weiss, Michael Reese, Franklin Boulevard, and Mount Sinai Hospitals
Karl A. Meyer, M.D.
Emeritus Professor of Surgery, Northwestern University Medical School, Medical Superintendent of Cook County Institutions, and Chief of Surgery, Columbus Hospital

Dr. Robert J. Freeark: I know of no problem in all of surgery that requires greater maturity of judgment and exacting technical skill than the management of a bleeding peptic ulcer. A large charity hospital such as this encounters many of these cases, often complicated by countless associated disease processes that only magnify and intensify the seriousness of the condition. The resultant morbidity and mortality rates often are alarming.

We are fortunate in having with us today to discuss the problem, two surgeons whose experience in this field is perhaps unparalleled, certainly so in this part of the country. Dr. Strauss and Dr. Meyer have fathered many of the current techniques and teachings of gastric surgery. Their vast clinical experience with the varied ramifications of the problem in both private and charity patients can hardly be surpassed.

Dr. Strauss has for many years pursued an active surgical practice at a number of prominent hospitals in this city. He was one of the first to champion gastric resection in the treatment of duodenal ulcer. His early achievements with this procedure were not well received by the surgical world in general, and I think its acceptance as an established treatment for peptic ulcer is a tribute to his foresight and courage. He is a most ingenious man whose contributions and accomplishments in all phases of surgery have received world-wide recognition. We look forward to hearing his discussion today.

Dr. Meyer needs no introduction to this audience. His inspiring role in this hospital, in the medical community of Chicago, and in surgical thought and practice in this country are well known to all. Throughout the nearly 50 years he served as medical superintendent and chairman of the surgical staff at Cook County Hospital, his major field of interest was management of peptic ulcer and its complications. Few men — whether scientists, surgeons, teachers, or administrators — can equal his contributions to the welfare of people suffering from this disorder.

Case 1.

Dr. James Apostol (Surgical Resident): This 59 year old white male was admitted to the medical service with a three day history of tarry stools associated with marked weakness. No ab-

dominal pain, nausea, vomiting, or change in bowel habits were present. There was no previous ulcer history. For 40 years, his alcoholic intake had been moderate to heavy.

On physical examination the patient was found to be somewhat obese. He was alert and co-operative but extremely weak and pale, with a temperature of 99.6° F., pulse rate of 108 per minute, blood pressure 132/60 mm. Hg., and tachypnea. The liver was three finger-breadths below the costal margin, firm and not tender. Spider nevi were present over the chest, with absence of hair. The stool was black and positive 4+ to benzidine. Hematocrit was 15%.

He was given three units of blood in the first 12 hours, and the hematocrit was then 21%. Emergency barium enema, requested because of the clinical suspicion of lower intestinal bleeding, was negative. The patient vomited three times after admission and the emesis was 0 to 1+ for benzidine. A Levine tube was inserted, with the subsequent return of coffee ground material that contained free acid and tested 4+ to benzidine. At this point, 18 hours after admission, the patient was transferred to the surgical service. After the fourth unit of blood had been administered, the hematocrit was 15% and he began passing dark red blood per rectum in large amounts. Four more units of blood were given rapidly, and he was taken to the operating room 24 hours after admission and after receiving a total of eight units of blood.

Dr. Freeark: We have selected this case because it is quite typical of the bleeding patient seen in this hospital. The history was negative for ulcer. The stigmata of cirrhosis were present, but we thought this was not a bleeding esophageal or gastric varix because of the absence of fresh blood in the stomach. We offer him to you as a diagnostic and therapeutic problem. Without giving you the operative findings we would be interested in your management of this case in particular and of bleeding ulcer in general.

Dr. Alfred A. Strauss: I would agree that this patient probably was not bleeding from the esophagus or stomach because of the absence of hematemesis and significant amounts of blood in the nasogastric tube return. Therefore, we would have to conclude that the bleeding was from the duodenum or farther down the intestinal canal. Duodenal ulcers sometimes give a hemorrhage such as this without pain, dyspepsia, or even nausea to suggest their presence.

There is one other condition that could possibly account for this type of bleeding and that is hemangioma in the small bowel. This possibility is realized only after a sad and bitter experience with it. In the early days, Dr. Leon Bloch and I operated upon a supposed bleeding ulcer. I did a resection but the man kept on bleeding and had tarry stools. This operation was done on a Monday and on Friday I brought the patient up again and opened him under local anesthesia. The chronic duodenal ulcer I had removed previously had not been the source of the bleeding because on second exploration I found a hemangioma five inches down the jejunum. This was simply excised and the bleeding stopped. I have run into this four times in my experience, so I call your attention to the fact that while you can have duodenal ulcer, you also may find some other source of bleeding below the point of the ulcer. You all know about Meckel's diverticulum, but that is uncommon in adults. It comes more often in the first 10 or 12 years of life. I would not expect any evidence of coffee ground material in the Levine return from Meckel's diverticulum.

As for the character of the bleeding, in my experience I would not look upon tarry stools as meaning necessarily bleeding from an ulcer. Once in a while there is a severe hemorrhage from a point in the cecum and the stool appears tarry. The fact that this man had tarry stools, however, suggests first a bleeding point in the duodenum. Bleeding from the stomach usually is associated with vomiting. I think this patient has a duodenal ulcer with a small hemangioma or other condition in the small intestine a remote possibility. I agree with your prompt surgical intervention when faced with evidence of continued blood loss. What did you find?

Dr. Freeark: At surgery the stomach was normal in its external appearance. The duodenum also appeared normal on its anterior surface. There was evidence of cirrhosis of the liver but none of portal hypertension. On careful palpation of the second portion of the duodenum a 1 cm., chronic ulcer on the posterior medical duodenal wall could be felt through the anterior wall, and this was readily accepted as the cause of bleeding. How do you handle this problem of low lying postbulbar ulcer?

Dr. Strauss: I would like to answer you this way: I had an interesting case many years ago, a patient who was having tarry stools. She was deeply jaundiced and in stupor from loss of blood. We transfused her but got nowhere. She came out of her stupor but sank back in. We explored her and found a large penetrating ulcer in the region of the duodenal papilla, with infiltration and obstruction of the common duct. I slit the anterior duodenal wall so I could attack it directly (today I would not be as heroic as I was in 1920). I excised the ulcer, put a small sound through the common duct to be certain I had not occluded its outlet. I then transected the duodenum above the ulcer and anastomosed the open end of the duodenal stump to the gall bladder to relieve the jaundice. We then performed a posterior polya type of gastric resection and gastrojejunostomy. Her liver was cirrhotic and about one-third normal size. Jaundice cleared rapidly and we have followed this patient for over 20 years. The most unbelievable thing is how that liver must have regenerated. I would not be so heroic today.

In patients with duodenal ulcer low down and with severe bleeding you must try to arrest hemorrhage first and then do a resection, if the patient can tolerate it. If not, just stop the bleeding and wait for a better time to do a subtotal resection. You cannot depend on the resection alone to stop the bleeding.

Dr. Freeark: If it is technically impossible to remove an ulcer in this location, would you be content with controlling the bleeding and omitting definitive ulcer surgery?

Dr. Strauss: If I have a severe gastric ulcer with the patient in bad condition, I believe either in excising the ulcer or throwing a ligature through it to stop the bleeding. Then close up and go in later for resection. With our usual duodenal ulcer penetrating deeply into the pancreas, if the patient is in good shape and you can do a resection, then I mobilize the duodenum below the ulcer, strip up the proximal duodenum, leave the ulcer bed on the pancreas, and close the relatively normal duodenum just below it. This is not possible with ulcers in the second portion of the duodenum.

Dr. Freeark: Dr. Meyer, you must have run across postbulbar ulcers that bleed. Will you give us your observations?

Dr. Karl A. Meyer: Postbulbar ulcers of this type are rare and cannot be resected. I remember one patient who had been explored with this type of picture and the surgeon did not find an ulcer and did not resect. They are easy to miss. In this patient, symptoms were severe but they were the combined symptoms of ulcer plus gall bladder disease in the same patient. Ulcer distress often was associated with jaundice. When you have this combination of severe ulcer symptoms and evidence of biliary tract disease, you must suspect a postbulbar ulcer with inflammatory involvement of the common bile duct. A high gastric resection, leaving the ulcer present, will control this problem. If the ulcer is bleeding, I would control it with ligatures and then resect above it.

Dr. Freeark: Dr. Strauss, how do you feel about barium study of the stomach and duodenum in the patient who is actively bleeding? Has this been helpful?

Dr. Strauss: I think barium study is a mistake in these patients.

Dr. Meyer: I disagree. We use barium study in every case where we are uncertain of the diagnosis. We have never observed any complications from it and we have achieved a high percentage of accurate diagnoses.

Dr. Frederic A. de Peyster (Attending Surgeon): In what percentage of cases have you found this study to be of value in pinpointing the ulcer? We have had some experience and it has not been satisfactory. The ulcers either are shallow or multiple and we have not been able to demonstrate them.

Dr. Meyer: We are satisfied with the radiologist's results when the ulcers are large craters. In those with multiple superficial erosions it is almost impossible to get a satisfactory study but you may find evidence in most of these cases of severe gastritis because such cases usually have multiple bleeding points and may suggest the need for continuing conservative therapy.

Dr. Freeark: What should we have done if we had not been able to palpate the ulcer? Would you recommend a gastric resection? Should we open the stomach and search? Should we open the duodenum and search? Or should we back out?

Dr. Meyer: Today in this type of bleeding the opinion would be in favor of a gastric resection

and I think that would be the conservative thing to do — a 75 per cent gastric resection.

Dr. Freeark: Would you precede it with gastrotomy?

Dr. Meyer: Sometimes you have to. Sometimes there is an ulcer or erosion high up and you discover it only at the time of gastrotomy. If the stomach is full of blood clots I would do a gastrotomy to evacuate it and inspect its interior.

Dr. Strauss: I am interested, Karl, in your enthusiasm for preoperative X-ray study. We have not used barium in patients with acute hemorrhage. I think probably in our type of work we see more cases with hemorrhage who have a previous ulcer history. But if there is no previous history, it has been our practice, if we think the hemorrhage is from the duodenum or stomach, to open the patient. If we find no signs of ulcer, I do not hesitate to open the anterior wall of the stomach. In some cases we have found hemangioma or small bleeding tumor that is not malignant but causes bleeding. If nothing is found, I do not hesitate to open the duodenum and look for it there. There are very few ulcers that you do not see on the outside. In some of those erosions on the anterior wall in young people you can see very little on the outside of the duodenum and you can see the bleeding site only by opening the duodenum. In our experience this has done no harm. You can do this, go in and look around, and find the lesion and do no more harm than with an X-ray examination.

Dr. Freeark: If you opened the stomach through a wide gastrotomy incision and found no apparent bleeding source, would you resect that stomach?

Dr. Strauss: I would open the duodenum to look for hemangioma or polyp. I would go right down to the ileocecal valve to look for the bleeding site.

Dr. Freeark: Suppose all of it is negative?

Dr. Strauss: Where there has been a lot of bleeding and if the patient is in good condition, you are better off doing a resection. I think the chances of saving the patient's life are better by doing a resection than to just put him back to bed because many of them will lose their lives the next week from another hemorrhage.

Dr. Freeark: In this patient we did what Dr. Strauss has suggested. The duodenum was opened longitudinally at the site of the ulcer, avoiding the area of the first portion. By holding the wall apart, two sutures were placed in the ulcer to control hemorrhage, the duodenum was closed longitudinally, and a 75 per cent gastric resection was done with closure of the duodenal stump and a Billroth II gastrojejunostomy. The longitudinal duodenal incision was below the area of duodenum turned in for stump closure. The patient is now nine days postoperative and has continued to do well without evidence of further bleeding.

Dr. de Peyster: Dr. Strauss, you have indicated that there are two aspects to the treatment of hemorrhage: (1) control bleeding, and (2) if the patient is in good condition, do a definitive procedure to prevent subsequent recurrence. You further stated that if the patient were in poor condition you would close after controlling the bleeding and would perform an elective operation later, usually subtotal resection. My question is this: In a poor risk patient after the bleeding is controlled, would you in the case of postbulbar duodenal ulcer consider vagotomy and gastroenterostomy or some other drainage procedure as definitive ulcer surgery?

Dr. Strauss: No, I would not. I think Dr. Meyer has done many vagotomies but I have done only a few. I may be a little slow but when this thing first came out, I thought it would take eight to 10 years or longer to find out just what the end results of vagotomy and gastroenterostomy would be. The follow-up of our stomach group (not done by the surgeon but by the medical men) showed that in somewhere between 90 and 95 per cent of the patients, subtotal gastrectomy was a satisfactory operation. As long as it is so satisfactory, I will not go to some other form of procedure until 10 or 15 years have elapsed when we are assured there is something better. There is no use in everybody experimenting with this new idea. As for pyloroplasty and gastroenterostomy, it takes little more surgery to do a subtotal resection and it is a much safer procedure from the standpoint of the patient's having a permanent cure.

Dr. Freeark: Dr. Meyer, does vagotomy have any place in the treatment of an acutely bleeding ulcer?

Dr. Meyer: I rarely utilize vagotomy in the treatment of an acutely bleeding ulcer. If the patient were very thin and I were reluctant to

do a high gastric resection, I might do a lesser resection and protect it with a vagotomy. I believe there are occasions when vagotomy and pyloroplasty may be applied to poor risk patients who will not tolerate a resection. In any circumstances, however, the bleeding point must be accurately controlled by ligature.

Case 2.

Dr. Richard Grossman (Surgical Resident): This 14 year old Negro female entered Cook County Hospital on May 4, 1958, with complaints of epigastric pain, hematemesis, and melena. History revealed previous difficulties of a similar nature since the age of 8. Hospitalization and radiologic study at that time confirmed the presence of a duodenal ulcer as the cause of a severe episode of abdominal pain. Ulcer management was instituted and was continued sporadically since that time. The first admission to Cook County Hospital was in 1951 for hypochromic anemia. Gastrointestinal complaints were not elicited at that time. In 1956, she was readmitted for hematemesis and weakness, and again in 1957. On both occasions she was in mild shock and required blood transfusions to restore hematocrit of 15% and 22% respectively.

Physical examination at the present admission was not remarkable except for evidence of moderate anemia. The patient appeared to be well developed but poorly nourished. Minimal epigastric tenderness was elicited on deep palpation. The stool benzidene was 4+ and hematocrit 17%. Subsequent gastric analysis with histamine revealed 70 units of free hydrochloric acid, although the unstimulated specimen contained little acid.

Dr. Freeark: These are the X-ray films obtained at the time of the patient's last admission. Throughout all her admissions to this hospital, ulcer would be demonstrated at one time and not at the next and these recent films were variously interpreted as showing ulcer and not showing ulcer. They were not particularly helpful in our decision. She had had several episodes of bleeding, a pain picture compatible with ulcer, but without the marked hyperacidity expected in a patient so young. The surgical department was asked to provide definitive care for this patient. Dr. Meyer, do you think she needed surgical care and what would you recommend?

Dr. Meyer: I suspect she received surgical care all right. Once a careful internist feels that medical management has failed or has become impractical, he will seldom have difficulty convincing his surgical colleague of this fact. Often the surgeon has reached this conclusion long before.

Here is a girl of 14 with a long history of pain, hematemesis, melena, and anemia. She has required repeated hospitalizations and periodic blood transfusions. While in none of her bleeding episodes does it appear that her life was in grave jeopardy, there is little doubt that for most of her last six years she has been in poor health. The normal activities of adolescence are not easily pursued when the hematocrit is 20%, abdominal pain is present, or the limitations of strict medical management are imposed.

The patient has been described as well developed but poorly nourished. Presumably she has reached her maximum growth, despite dietary restrictions and chronic blood loss. She enters now with acute upper gastrointestinal hemorrhage. Many such cases are admitted here with this problem. When they bleed they become frightened and the much needed but avoided hospitalization becomes mandatory. Spontaneous arrest of hemorrhage permits time for diagnostic studies and intensive preoperative preparation. They should not greatly influence your decision in this case. Previous studies have demonstrated a logical cause of this patient's difficulty and it should be dealt with accordingly. This patient should be operated upon. I would be conservative only in my choice of surgical procedure. I favor a vagus resection combined with removal of the distal half of the stomach.

It is not the problem of recurrent ulcer that concerns us here so much as the postoperative symptoms that may develop. Radical subtotal gastrectomy will certainly control the ulcer diathesis, but in a poorly nourished 14 year old girl it may seriously impair both digestion and nutrition. By preserving a major portion of stomach and protecting that otherwise inadequate resection with a complete vagotomy, I believe recurrence will be rare and recovery hastened. Vagotomy with gastroenterostomy might be adequate, but she has many years ahead of her in which to develop a new ulcer, and I would feel more protection is provided the bleeding ulcer patient if a portion of stomach is resected and the gastrointestinal continuity restored by a Billroth II gastrojejunostomy. To prevent this girl

from having recurrent bleeding, she should be operated upon with a conservative procedure.

Dr. Freeark: What are the implications of a relatively normal acid as opposed to severe hyperacidity in your choice of procedure?

Dr. Meyer: With a patient of this age and a normal acid, I would favor a conservative procedure even more strongly. But if the patient has high acid and marked retention, especially excessive night secretion with high acid content, I would elect to do a 75 per cent resection. In very severe hyperacidity I would do a vagus resection at the same time. In my private patients at Columbus Hospital just as at Cook County Hospital, we advocate a complete gastric acid survey in all ulcer patients. On this may depend the type of resection we are going to do, whether it is high or a lesser resection with vagectomy.

Dr. Freeark: Dr. Strauss, what would your observations be on the management of this patient? Did we wait too long?

Dr. Strauss: I would not criticize the waiting in this case. I have operated on five cases of duodenal ulcer in children ranging in age from 10 to 16 years. Curiously, four were in girls. All were large indurated ulcers with severe symptoms of obstruction, bleeding, or unremitting pain. I did not do as high a resection in them as I would have if they had been older. I took off a little more than half. I really am a novice when it comes to vagotomy, having little experience with the procedure. I have been conservative in accepting it, but I have an open mind and some day I may start doing vagotomy, but I will wait until I see the results. I do vagotomy now where I have recurrent ulcer following subtotal resection. I have one case in whom the late John B. Murphy had performed a gastroenterostomy. This was in the days when simple gastroenterostomy was an acceptable procedure. The patient came to me with symptoms similar to a dumping syndrome. I explored the patient, found no evidence of ulcer, and took down the gastroenterostomy. Within a short while my judgment was proved wrong, when she developed a large duodenal ulcer. I reoperated and did a resection. About six months later she developed a gastrojejunal ulcer. I then did a re-resection. Some time later I had to carry out a third resection which was combined with a Witzel feeding jejunostomy, before the ulcer diathesis was controlled. Surprisingly, she recovered and did well for many years after that. Perhaps this was a candidate for a vagotomy. I do not want you to think that I do not have an open mind. Maybe in a year or so I will follow these teachings of Dr. Meyer.

Dr. Freeark: Our exploration of this patient revealed an unimpressive but obvious anterior duodenal scar suggestive of previous anterior wall ulcer. However, the ulcer was not striking in its apparent chronicity or in its degree of scarring. Her hematologic status had been carefully evaluated and there seemed to be no detectable bleeding tendency to account for the frequent episodes. We did a vagotomy and a 40 to 50 per cent gastric resection. She had an uneventful course and in the past year has had no further bleeding or pain.

Dr. Robert Baker (Director of Blood and Parenteral Therapy, Cook County Hospital): How would you handle the acutely bleeding juxtaesophageal ulcer that cannot be removed without total gastrectomy?

Dr. Strauss: Usually those are severely bleeding ulcers and present difficult therapeutic problems. I would like to cite a classical case from my own experience. The patient had bled severely and I suggested that we operate at once and not wait, but the attending medical man said that we should wait. So at 4 a.m. I was called back to the hospital. I excised this ulcer near the cardia and the patient got well. The point is that a gastric ulcer up there usually has more blood supply than in other parts of the stomach and will bleed profusely. These patients should be opened up and explored carefully. If nothing more, make a wide open gastrotomy incision and excise the ulcer. You have to do something.

Dr. Freeark: How do you feel about taking out ulcers in the first portion of the duodenum?

Dr. Meyer: This is unnecessary if you have controlled the bleeding. Efforts to remove these ulcers increase the possibility of a blowout of the duodenal stump. This is one of the most serious complications that can occur in gastric surgery. If you try to reconstruct the duodenum after the stump has blown out, the patient will die. The simplest thing to do is make a subcostal incision and put down a Chaffin tube and you will save most of those patients. We had a patient who was operated upon who had been up and about for 14 days and then the duodenal stump blew out. We put in subcostal drainage with a tube

and he was all right. Some time later he blew out the second time and we did the same thing. That is the most serious technical complication you have, and the place to prevent it is in the operating room.

Dr. Freeark: What measures do you take to protect the duodenal stump?

Dr. Strauss: I take the free edge of omentum and suture it with interrupted sutures over the whole suture line. I also use a firm rubber tube as a drain.

Dr. Freeark: How do you feel about a catheter in the duodenum for a controlled fistula?

Dr. Strauss: I have not done that. I have heard other men talk about it but I have not done it.

Dr. Meyer: I never do it. Incidentally, Dr. Nelson Percy reported that first. When we have a difficult case we close the stump as securely as possible, insert a Chaffin tube down to Morrison's pouch, and connect it to a source of continuous suction. That usually will handle any trouble should a blowout occur. Closure of a duodenal stump can be very difficult and I advise the residents to utilize this tube with continuous suction, keeping the tube away from the line of duodenal closure. Many people make the mistake of placing a drain down onto the duodenum. Keep away from the duodenal stump itself. Otherwise you will produce a fistula that is largely man made. The tube belongs in that recess between the upper pole of the kidney and the under surface of the liver that is adjacent to the stump.

Dr. Nicholas Capos (Attending Surgeon): This is a rare occasion. We are honored to have with us Dr. Strauss and Dr. Meyer who are the real pioneers of modern gastric surgery. Most of us were not born or were wearing diapers when they were developing the current surgical technics we utilize today. I have enjoyed this discussion immensely.

Dr. Meyer: Dr. Strauss and I graduated in the same year [1908] — he from Rush Medical College and I from the University of Illinois. We have been close friends for 52 years, and we have been keen competitors in surgery of the stomach. Dr. Strauss's first work in surgery of the stomach was for pyloric obstruction; in fact, I believe he once transplanted fascia from the thigh to repair a surgically created defect in the pylorus in some of those early cases. He is the real pioneer in gastric surgery.

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C.V. data in nonagenarians

The absence of hypertension and cardiac enlargement in the very old may be due entirely to the nonsurvival of the hypertensive individuals. However, other factors may contribute to reduction of blood pressure in old age. These many be neurogenic, particularly sympathetic nervous system influences on vasomotor tone and peripheral resistance, humoral factors associated with nephrosclerosis, and increased emotional stability in sheltered environments for the aged. The frequency of low serum cholesterol and elevated blood sugar levels suggests the effect of dietetic factors. *Norman N. Frenkiel, M.D. Cardiovascular Data in Thirteen Nonagenarians. Geriatics Sept. 1959.*

EDITORIALS



The voice of the patient

The patient's voice in the form of public opinion determines to a great extent the type of research that will be conducted on a national level. William McPeak, vice president, Ford Foundation, made this clear at the dedication of Stanford's new medical center in Palo Alto. The patient's voice is "amplified" by organizations publicizing one particular disease, by philanthropies, and by government agencies. These voices swell into a vast chorus of dread and fear. Stress is placed on a dramatic disease even though — like polio — it may not be widespread, and on the big killer, list like heart disease and cancer.

In the same talk Mr. McPeak took the medical profession to task by stating that the voice of the patient was not always heeded in the office of practicing physicians. His complaint brings home one of our basic problems in public relations and none of us can disregard such criticism.

Most physicians are so sensitive about complaints that reflect incompetence and excessive fees they have forgotten the very thing the public wants to cherish and preserve — that old doctor-patient relationship. The physician should do all in his power to preserve his part of the relationship.

Mr. McPeak strikes at the heart of the problem by criticizing us for fostering our sense of personal convenience in the office, home, and hospital. We are obsessed with the idea that no one but ourselves is busy and that everyone should wait for us. This might be true in an emergency but nowadays, more than 90 per cent of our work is elective or in the realm of preventive medicine.

This situation is not necessarily gross neglect of the feelings of our patients; in many instances, it is mismangement such as making too many appointments at the office for the same time. An office full of patients was good showmanship in the past but is now regarded as poor management by business executives and provides ammunition for those who want state medicine.

Mr. McPeak believes also that many patients regarded unnecessary hospitalization as a way of arranging things largely for the physician's convenience. The history, examination, and laboratory test could be done in the office but it takes time. Hospitalization is one way for the busy physician to see more patients and do a more thorough job. But it has obvious repercussions, especially when Blue Cross refuses to pay the bill and interns get discouraged because they must perform services that should be done by the attending physician.

He also objected to "the patient's dependence upon the doctor's expertise." The physician's air of knowing all the answers is revolting to some patients, especially to those who are intelligent and over the years have accumulated knowledge from reading scientific reports in newspapers, magazines, and books. Our public relations might improve if we were a bit franker concerning the

limits of medical science and admitted that progress takes place so rapidly it is difficult to keep up with the latest remedy.

"Patients feel subordinated by the doctors not only medically but also personally. In many doctors' offices they feel like ciphers. Too often their doctors strike them as either insensitive or indifferent. Anyone knows of several poignant incidents resulting from the attitude of doctors in modern practice and hears of many more. It is unnecessary to repeat them. What undoubtedly is involved is the personality change in the man who is becoming more and more the specialized scientist. With specialization, there necessarily follows a narrowing of the base for human contact. No one doubts that the shift in medicine has brought more gains than losses, but it cannot be said too often that the gains do not permit us to ignore the losses, especially when the losses are so much in the patient's sphere. We must remember what medical care is all about and that the word care has a human, as well as a technical meaning."

These criticisms — right or wrong — are easily corrected. This is grass roots public relations in its basic form. There is no doubt that some people feel the same way about the medical profession as does Mr. McPeak. It is much easier to change a few attitudes than to change an entire way of practicing medicine such as these patients may enforce through government intervention.

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The coronary hunting and fishing club

President Eisenhower has many physicians in addition to those assigned officially to supervise his heart problem. Some of these armchair authorities are men of extensive experience; others are not M.D.'s but laymen who profess medical ability.

One of the main issues in the President's care is concerned with his varied physical activity, particularly his participation in sports. His recreations include golf, fishing for trout, and quail hunting. His official physicians undoubtedly approve of this form of exercise and presumably most of his armchair doctors concede it has been beneficial. His record has certainly done much to "liven up" the many coronary patients in the United States whose restrictions were so heavy in past years. Whether all coronary patients can pattern their hunting and fishing activities on Mr. Eisenhower's record is another problem. The electric golf cart has eliminated most of the exercise and strain of golfing.

Rules for authors

Manuscripts should be submitted in duplicate to the Illinois Medical Journal, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4,500 words; briefer if possible.

Footnotes and references should conform to the following style in the order given: Name of author; title of article; name of periodical; with volme, page, month — day of month if weekly — and year. The Illinois Medical Journal does not assume responsibility for the accuracy of references used with scientific articles.

The first page should list the title, the name of the author (or authors), degrees, and any institutional or other credits. The title of the article should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered, and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively, indicating them in the text. Number, indicate the top, and place the author's name on the back of each illustration. Number legends and type them following the main body of the manuscript, not on the illustrations.

Order blanks for reprints will be sent to the author at the time of publication.

Address manuscripts to Editor of the Illinois Medical Journal, Suite 1909, 185 N. Wabash Ave., Chicago 1, Illinois.

Many internists and cardiologists advise their coronary patients to develop an exercise program within the limits of their individual capacity and hunting and fishing often are included. It is not uncommon to encounter an old coronary patient in one of the many duck camps up and down the river. We cannot refrain from thinking of the possibility of a second coronary while out in the duck blind on a good duck day — which means bad weather. Should this misfortune occur, and his companions are on the ball, they won't walk the patient to the club house in the wind and snow. Probably they couldn't improvise a litter to carry him but help should be sought as rapidly as possible. This means whisky, a physician if there's one in the party, a litter, and pushers to carry the patient to a waiting ambulance and thence to the hospital and standard medical care. The same rules would apply to fishing and other types of hunting.

Some coronary patients should never hunt or fish. Experience has indicated, however, that nearly all patients recover from their first coronary attack (uncomplicated) and are readily rehabilitated to reasonable levels of physical activity. If the hunter has survived two coronaries, or even three — and this is not unusual — he should be assayed carefully by his physician as to his capacity and ability to hunt and fish. Not all hunting and fishing is as arduous as handling a heavy 12 gauge shotgun in a duck blind or wading a rocky river with a fly rod and accessory gear.

An old hunter might well be advised to content himself with dove hunting with a rocking chair on the shady side of a pig house with his favorite grandson to spot the incoming birds, then shooting them with a 20 gauge Winchester 21. The grandson could retrieve the birds for him and for the younger one's effort he would be rewarded by words of wisdom on how to handle a gun safely and how to hunt. You can fish from a boat with a fly rod so light the effort is no more than that of saluting a passing friend on the street. If the cast is successful, landing the catch is a feat well within his muscle power. Again, you can teach the young, when physical prowess must be limited.

Summing up the evidence, it would appear that a heart attack does not deprive the heart patient of hunting and fishing after he has been rehabilitated. He must learn his limits, however, through his physician and his own experience and keep within them. He must be temperate and have selective judgment about where he goes to hunt and fish. But the period of caution does not end with the hunt. At the end of the day he must remember to count the jiggers of Bourbon that go into his glass.

Chauncey C. Maher, M.D.

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A co-operative venture

The Chicago Maternity Center is the largest outpatient obstetrical clinic in the United States. It is an example of how several agencies co-operate to furnish the community with an indispensable service. Any large medically indigent population that lives in a congested urban area presents problems in regard to obstetrical care that are magnified by ignorance and racial differences.

Two-thirds of the Center's patients are registered and receive prenatal care at the Center or in a clinic of a referring agency. These are women who, for one reason or another, prefer to deliver their babies at home. Many find it difficult to provide supervision for their families during hospitalization. About 200 such women deliver in their homes each month.

In addition to the registered patients, the Center cares for 75-100 unregistered women each month. These mothers have had little or no prenatal care and many have delivered unattended before the Center is called. Infant mortality is higher in this group, due largely to an increased number of premature births.

Patients unsuited for home care are hospitalized chiefly at Chicago Wesley Memorial Hospital because of a joint program between this hospital and the Center. This assures continuity of care to the patient and teaching for the residents. However, other private hospitals and Cook County accept patients when it is necessary.

Two to three clinics are held daily at the Center, including prenatal, postnatal, pediatric, medical, and gynecological clinics. They are staffed by qualified physicians, board certified in their respective specialties.

The Center is not only a service, but a teaching agency; every case is used for teaching purposes. Living in are residents, assistant residents, medical students, and nurses. The residents aspire to board certification and are part of a

joint program participated in by Northwestern University Medical School, Chicago Wesley Memorial Hospital, and the Chicago Maternity Center. On this service, residents spend one year and assistant residents, six months. All of the senior medical students from Northwestern University Medical School and the Chicago Medical School spend two weeks at the Center. A paid instructor supervises the resident personnel and teaching seminars are held on Wednesday and Friday of each week.

On the nursing staff are eight nurse-midwives. Some hold master's degrees from Columbia or Yale Universities and all are registered nurses who have had special obstetrical training in a midwife program. These nurses do not deliver babies, but are helpful in teaching obstetrical techniques.

The chief advantage derived from home delivery by the student is the opportunity to assume some responsibility, to observe and follow labor throughout its course by abdominal and rectal examination, and to deliver a baby. A student averages from eight to 10 deliveries during his stay at the Center.

The volume of deliveries, from 3,000 to 3,600 per year, provides residents and assistant residents with a variety of pathology, which are challenges from the standpoint of diagnosis and management.

Michael Reese Hospital sends a pediatric resident to the Center for one month's training. Most of the babies who are hospitalized go to Michael Reese. This again assures continuity of care and teaching.

The greatest danger threatening the life of the woman who delivers at home is hemorrhage. The Michael Reese Blood Bank furnishes the Center with plasma and blood for transfusions, which help save maternal lives. In extreme emergencies, transfusion is given without cross-matching. In the past year, two patients with spontaneous rupture of the uterus and one with abruptio placentae were transfused en route to the hospital. All lived.

The Visiting Nurse Association gives postpartum care and at one month of age, the babies are referred to a clinic of the Infant Welfare Society or the Chicago Board of Health.

The Center is a fine example of how a group of medical students, physicians, and nurses — working under the supervision of trained personnel with the co-operation of other clinics and hospitals — can maintain an excellent maternal and infant mortality rate in a home delivery service. The Center has delivered 14,600 consecutive mothers in the home without obstetrical death. A few referred to hospitals for delivery have died and in these cases, the Center shares the responsibility with the patient and the hospital. The neonatal death rate for the first nine months of 1959 was 13 per 1,000 live births.

A 10 year study of the infant mortality rate at the Center (1945-1955) reveals some interesting facts. Under the same conditions of delivery care, the Negro child survives as well as the white child. The optimum birth weight for survival for each is eight pounds. The death rate of the premature Negro baby is less than that of the white premature, but twice as many 10 pound negro infants are lost as white infants.

The Chicago Maternity Center is a private charity financed by individual donations and the Community Fund of Chicago. The anticipated budget for 1960 is $300,000. In the first six months of 1959, the Center cared for over 2,800 individual patients, either in the home or in the clinics.

Beatrice E. Tucker, M.D.

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Committee on impartial medical testimony

Since the United States District Court adopted impartial medical testimony, the chairman of the Council appointed the following committee to have charge of the various aspects of this procedure:

Samuel A. Levinson, chairman; Newton DuPuy, Arthur F. Goodyear, Percy E. Hopkins, Richard J. Bennett, Aaron Kanter, LeRoy H. Sloan, Norman Robert, Wright Adams, Clinton Compere, Roland McKay, Harold Voris, Roger Harvey, Ken Roper, Vivian Siegel, John Condon, and Warren Young. In addition, the president and president-elect of the ISMS and the CMS will serve also on this committee as ex officio members.

All panel physicians who are to appear as impartial witnesses will be selected carefully and will be outstanding men in their fields.

Unpaid bills

There are many ways to collect bills and to weed out the poachers. The old-timers were known for their charity but condemned the deadbeat who neglected his responsibility. The following notice, issued by Dr. Z. Hickman and associates of Benton some 82 years ago, was submitted to Dr. Lull by the Benton attorney, R. E. Hickman, a son of Dr. Hickman.

To The Public

We, the undersigned physicians of Benton, request all persons indebted to us, by note or account for services rendered prior to Jan. 1, 1876, to call and settle within thirty days, by paying part in cash and the balance in produce or secured note.

All able-bodied persons, whose accounts have been running from one to five years, failing to settle, as above requested, with any one of us to whom they may be indebted, will positively be refused further medical attention until their accounts are settled.

All persons who are physically unable to work, and who are financially unable to pay us, shall receive our services Free of Charge: provided, the county will pay for the medicine furnished.

All ague medicine must be paid for in cash.

If you will come forward and discharge your obligations, by settling your accounts it will enable us to do likewise.

Z. Hickman
A. G. Orr,
J. Smith,
W. D. Burress,
G. B. Hoblit.

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Medicine on postage stamps

Recent issues of postage stamps of medical philatelic interest include the following:

Argentina—Three distinguished medical scientists are shown on stamps in connection with the 21st International Congress of Physiological Sciences in Buenos Aires: William Harvey, English discoverer of circulation of the blood; Claude Bernard, French endocrinologist; Ivan P. Pavlov, Russian winner of 1904 Nobel Prize in physiology and medicine.

Finland—A set of three semipostals, showing flowers, was issued for the benefit of the nation's antituberculosis work.

France—A 20f commemorative pays tribute to the fight against polio and publicizes vaccine. It shows a boy throwing away his crutches. A "Famous Men" series includes a 30f plus 10f stamp with a portrait of Marie F. X. Bichat, French anatomist and physiologist. Two Red Cross semipostals honor Frenchmen for their work in education of the blind and deaf and dumb.

Germany (Eastern)—Two stamps commemorate the 200th anniversary of the birth of the poet, Frederich Schiller, a physician as well.

Germany (Western Berlin)—A 2pf stamp honors Schiller.

Korea—The World Health Organization emblem is superimposed on the United Nations emblem on a 40h stamp.

New Zealand—The 1959 health stamps picture birds in color.

Peru—Four airmails commemorate the centenary of the birth of Daniel Alcides Carrion Garcia, considered a martyr to Peruvian medical science. Included in the designs are protraits of Carrion, and of Hipolito Unanue, regarded as father of Peruvian medicine. The facade of the old San Fernando Medical School also is pictured.

Philippines—Two sets of semipostals were issued to publicize the antituberculosis campaign.

Poland—A "Famous Scientists" series of six stamps includes portraits of Nicholas Copernicus, Polish physician who gained fame as an astronomer; Louis Pasteur, discoverer of pasteurization; and Charles R. Darwin, who although not a physician had studied medicine and who gave to the world his theory of evolution. Two other stamps commemorate the International Esperanto Congress. One bears the portrait of Isaak Zamenhof, physician, who created Esperanto.

United States—Dr. Ephriam McDowell, Kentucky surgeon who in 1809 performed the first oophorectomy on record, is pictured on a 4¢ stamp.

The 100th anniversary of the Battle of Solferino, Italy, the horror of which led Jean Henri Dunant, Swiss humanitarian, to found the International Red Cross, has been commemorated by additional postal issues, including the following:

Chile—Two values show the portrait of Dunant.

Greece—An attractive set of seven stamps was

issued in connection with the opening of the 25th International Red Cross Congress in Athens. The designs include a bust of Aesculapius, a picture of Hippocrates' famous plane tree at Kos, a portrait of Dunant, and a picture of the Good Samaritan in color.

Iran—Two stamps show a white banner and figures symbolic of the Red Cross.

Korea—Two stamps commemorate the centenary of the Red Cross and the 10th anniversary of the founding of the Korean Red Cross.

Pakistan—Two stamps commemorate the centenary.

Poland—Three stamps honor the centenary of the International Red Cross, the 40th anniversary of the Polish Red Cross, and the 15th anniversary of the Red Cross in the Polish People's Republic.

Togo—Three stamps honor the Red Cross.

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Editorials from other journals

The crumbling cordon of confidentiality

If a claimant is denied a benefit under social security or disability insurance he is entitled to see the medical report on which this denial is based. This puts the doctor on the horns of a dilemma. If he refuses to issue a statement, his patient may be denied any benefit. If he issues a truthful statement which the patient can look at, this may cause ill will between doctor and patient. The physician under these circumstances might be tempted to say: "A plague on both your houses."

While such a reaction is understandable, it is not in accordance with a doctor's responsibilities. Furthermore, this is merely one more aspect of third part coverage. A large proportion of doctors' bills today are paid by third parties: Blue Shield, Veterans Administration, labor union insurance plans, retirement boards, welfare agencies, and the like. If these agencies pay the bill they want to know the diagnosis. There is no escape from this. It is unlikely that we are ever going to see any return to the days where most people paid doctors out of their own pockets and thus assured themselves of a truly private relationship.

Perhaps this will lead to a kind of medical double talk. You cannot brand the patient a malingerer because he may see your report. So you say instead that you are unable to find any medical evidence to account for the symptoms. It is possible to designate alcoholism under a euphemism and even venereal diseases can be described in long medical terms that seem much less stark than syphilis and gonorrhea. But these are only subterfuges.

To collect your bill, you fill a form. This is delivered to an office where a mail clerk opens the envelope and glances at the form. It then is carried to an "In" basket and reviewed by a clerk at a higher echelon. It reaches another tray where a reviewing authority validates the payment of the bill or relays the form to a medical official for determination. And So Mr. Mayor's hemorrhoids or Miss X's trichomonal vaginitis are thus noted by a bevy of clerks.

A citizen's health is not the only aspect of life where private affairs can become public displays. Any one can get your name from your automobile license tag. In some places, commuters carry tickets with their pictures and addresses. And your income, once a secret between man and wife, is now on record so that a corps of clerks may cluck over it.

Once there was built a dike of confidentiality between doctor and patient. It is not coincidence that the words "confidence" and "confidentiality" sound so much alike. The dike is crumbling; there is no escape from the fact that he who pays the piper calls the tune. *J. M. Soc. New Jersey Oct. 1959.*

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Council meeting minutes

First meeting

The regular December meeting of the Council was held Saturday noon, December 12, 1959 at the LaSalle Hotel, Chicago, with the following present: O'Neill, Hamm, Burdick, Clark, Redmond, Adams, Portes, Piszczek, Dooley, Endres, Reisch, DuPuy, Goodyear, English, Montgomery, Fullerton, Klein, Oldfield, Oblinger, Mirt, Bennett, McCarthy, Hopkins, Compton, White, Neece, Hamilton, Limarzi, Mr. James Worthy, and Frances Zimmer.

Dr. Montgomery, as chairman of the Council, read the following tribute to Dr. Camp:

Harold M. Camp, M.D.

1885-1959

"Today, as we gather to consider matters vital to the future of the Illinois State Medical Soci-

ety and of medicine in Illinois, there is a vacant chair. That chair will be difficult to fill because it has been occupied for 35 years by a man whose memory will be cherished and whose works will be long remembered by all who have come to know him.

"Dr. Harold M. Camp, Secretary of the Illinois State Medical Society since 1925, Treasurer since 1942, and Editor of the Illinois Medical Journal since 1941, passed to the Great Beyond on October 17, 1959.

"Unwilling to admit any knowledge of his terminal illness, he labored until a few days before his death. This was as he would have it.

"Dr. Camp was born in Brooklyn, Schuyler County, Ill., July 24, 1885. He was a son of the late Dr. Julian E. Camp, who devoted a half century to administering to the ills of mankind. The son was to follow in the footsteps of his father, and to imprint his name indelibly upon the history of medicine in Illinois.

"Harold Camp obtained his medical degree from Northwestern University Medical School in 1909. In June of 1959, he was given the University's Merit Award 'in recognition of worthy achievement which has reflected credit upon Northwestern University and her alumni.'

"After interning at the Englewood Hospital in Chicago, he took up the practice of medicine in Monmouth. The gentleness of his disposition, the simplicity of his manner, and his skill as a physician quickly endeared him to his patients.

"Organized medicine early commanded the attention of this remarkable man, first at the county level, then at the state and national plateaus. As a delegate, a councilor, and as secretary-treasurer, he gave more than 40 years of his professional life to the welfare and growth of the Illinois State Medical Society. He was a pillar of strength throughout that period.

"Dr. Harold Camp is dead, and there is a great void in our organization. However, he leaves with us the memory of a man whose untiring efforts helped to raise the standards of medicine in Illinois and who was one of the strongest champions in the fight against the intrusion of socialized medicine. This is our heritage, and should be an inspiration for unselfish conduct of all of us in the trying days that are ahead of us."

Dr. Fullerton asked that this tribute be read to the members of the House of Delegates.

Dr. E. V. McCarthy was given the privilege of the floor by the chairman. He reported a membership case which occurred at the time he was chairman of the membership committee for the Chicago Medical Society. The physician in question was voted into membership by the CMS, reported to the office of the ISMS, and subsequently reported to the AMA. It was Dr. McCarthy's opinion that the original action taken by the CMS Council was not in order. He stated that he felt the action of the ISMS was taken in good faith, and desired only the privilege of reporting his opinion in the case. He felt that the Council should look into the matter and see if the Constitution and Bylaws of the state society were followed. Dr. McCarthy was assured that the Council would take the matter under consideration.

MOTION: (Fullerton-Piszczek) that the minutes of the October 11 Council meeting be approved as mailed to members. Motion carried.

COMMITTEE ON MEDICAL SERVICE & PUBLIC RELATIONS

Dr. Hamilton reported briefly on the activities of the Committee on M. S. & P. R. The crash program organized and spearheaded by the committee against the Forand type legislation has gone on in good fashion. Meetings have been held in all but about 10 counties — primarily those counties where there are only 8 to 10 members. The men are being urged to attend meetings in nearby areas. Dr. Hamilton commended Oblinger, Scott, Neal, and Mirt for the assistance given the committee.

The questionnaires which have been returned have been tabulated on IBM cards (courtesy of Blue Shield — Robert Evans). Of the approximately 9,500 which were mailed out, 3,854 have been returned, or about 40 per cent. Most replies were to Questions No. 1 and No. 2. These indicated that 82 per cent of the physicians were in accord with the AMA proposal to take care of the problem, and that 86 per cent were prepared to go along with a Blue Shield payment in full plan. It was the feeling that the physician should not, and cannot, assume this burden unless all other segments of the medical care team were willing to accept lower compensation.

The median of what was considered low income in the development of a plan for those 65 or over approximated $2,500 yearly for an indi-

vidual and $3,500 for a family. No compilation was made of opinions concerning modest resources as many physicians confused this with income.

Question No. 4 was "What fees would you agree to accept that you believe are commensurate with the income and resources of this group of persons? (payment in full)." This had three subsections. However, only the first subsection, concerning the acceptance of a Blue Shield Medical-Surgical Plan, received enough answers to provide a significant return. Opinions were expressed in 2,378 replies (61 per cent). Of these, 2,171 were agreeable to co-operate with such a plan and 207 were not.

Fifty per cent of the returns came from Cook County, 47 per cent from counties outside of Cook, and 3 per cent either failed to state the county or listed more than one.

Dr. Hamilton stated that his committee had not had the opportunity to develop a recommendation relative to the $150 million bond issue for the Department of Public Welfare, nor to make a report on the relative value study.

He would recommend that a committee be appointed to go into the problem of relative value and report on this question. There was some discussion relative to the entire picture and relative to the thinking at the AMA level.

MOTION: (Goodyear-O'Neill) that the Council appoint a committee to study and report to the Council on the relative value study. Motion carried.

The Committee on Medical Service and Public Relations will be relieved of this responsibility, and the new group will function as a committee on information so that all phases of the question can be discussed. The Ad Hoc Committee, headed by Dr. Hopkins, has been working on the task of securing an administrator and a public relations director. A firm has been employed to process the applications of candidates and to make recommendations in both the field of administrator and public relations director. This is a report of progress and no action is needed.

ANNUAL MEETING COMMITTEE

Dr. Lull reported for Dr. Lorne Mason as chairman of the Annual Meeting Committee.

(1). That a special committee be appointed by the Council for the purpose of developing the scientific programs for the General Assemblies. This committee is to be composed of nine members, three appointed each year for a term of three years, with the president, president-elect, and immediate past president, ex-officio.

MOTION: (English-DuPuy) that the council approve the recommendation. Motion carried.

(2). MOTION: (Piszczek-Endres) that a flyer be sent to all members of the Society for the 1960 annual meeting. Motion carried.

(3). This recommendation is being given consideration — that the Council and/or the House of Delegates consider a fall meeting of this Society.

(4). MOTION: (Piszczek-Fullerton) that the Council authorize the development of scientific movies for the 1960 meeting, and that Dr. Coye C. Mason be asked to serve again as chairman of this activity. Motion carried.

(5). MOTION: (Endres-Fullerton) that the secretary contact the Academy of General Practice relative to credit rating for the 1960 annual meeting, and that publicity be given either the Class I or Class II rating established. Motion carried.

(6). MOTION: (English-Portes) that the meetings of the House of Delegates be held as follows: 1st meeting — Monday evening, May 23; 2nd meeting — Wednesday morning, May 25; 3rd meeting — Thursday morning, May 26. Motion carried.

(7). MOTION: (Piszczek-Adams) that the secretary secure the services of an exhibit manager to work with the commercial exhibitors during the 1960 annual meeting. Motion carried.

(8). MOTION: (Fullerton-Portes) that prizes be given for registration at commercial exhibit booths as was done last year, that a committee be appointed to purchase the prizes, and that $500 be allocated. Motion carried.

(9). MOTION: (Endres-Fullerton) that the Auxiliary be asked to assist with the annual dinner. Motion carried.

(10). MOTION: (Fullerton-Portes) that the Committee on Medical Service and Public Relations be asked to have a luncheon meeting Tuesday noon with the Committee on Medical Testimony. Motion carried.

(11). There is a definite need for more detailed publicity, and everything possible will be done to keep the membership informed.

MOTION: (Endres-Fullerton) that all sec-

tion meetings be held within the format of the annual meeting. Motion carried.

(This action would mean that the Section on Anesthesiology would meet on Tuesday afternoon as stated at the meeting of the section officers in November.)

COMMITTEE ON CONSTITUTION AND BYLAWS

Dr. Goodyear reported for the Committee on Constitution and Bylaws (since Dr. Bornemeier was not present) and outlined the suggested changes prepared for the consideration of the House of Delegates. Copies of the Constitution and Bylaws as amended in 1959, and copies of the suggested changes are available for members of the House.

MOTION: (Adams-Piszczek) that the report be accepted. Motion carried.

COMMITTEE ON INDUSTRIAL HEALTH

Dr. Richard J. Bennett reported as chairman of the Committee on Industrial Health. The work of the committee in the field of impartial medical testimony has been under way for one year this month. The panels are being used in Federal District Courts at the present time. On November 2, the federal judges met and decided that they would make use of the panels; their vote was unanimous. The panels have been used about seven times to date and the impartial medical testimony is working well. The cases are interesting, and medical truth is the basis on which we hope to popularize the program.

The legislature does not meet for two years, and there is a question of money for the program in Illinois courts. New York has funds available, and some other States where the program is used, have made appropriations. The program in Illinois will have to win approval. The Illinois Bar Association and the Chicago Bar Association both have to vote, and there is a political background to meet before we can get this accepted in Illinois state courts. For Federal Courts the panel rotation has been picked and set up, and the material is in the ISMS office at 185 North Wabash Avenue.

On November 24, the ISMS Committee on Industrial Health voted to turn back to the Council this problem of impartial medical testimony, with suggestion that a new committee be appointed to work under that title.

The old committee would like (1) to resign, (2) to ask that a new committee be appointed, and (3) that the expense of printing and distributing one of the papers given, and a guide for panel experts, be approved.

MOTION: (English-Piszczek) that the recommendations of the committee be approved. Motion carried.

MOTION: (English-Oldfield) that Dr. Charles P. Blair of Monmouth, Dr. Earl H. Blair of Chicago, and Dr. George F. Lull represent the ISMS at the AMA Conference on Civil Defense, to be held in Chicago, January 23. Motion carried.

MOTION: (English-Piszczek) that Dr. Lull notify the Governor of the suggested names for appointment of the Commission on Mental Retardation and the Commission on Mental Illness. Motion carried.

(Oblinger called the attention of the Council to the fact that the Commission on Narcotics would also be appointed soon).

MOTION: (Endres-Fullerton) that Dr. Lull be instructed to secure insurance (public liability, fire, and theft) for the Society for the annual meeting next May. The cost will be approximately $50. Motion carried.

MOTION: (DuPuy-Fullerton) that resolutions be prepared for the families of Dr. Harold M. Camp and Dr. Roland R. Cross. Motion carried.

MEMORIAL FOR DR. CAMP

Dr. O'Neill discussed the question of a memorial in honor of Dr. Harold M. Camp for his many years of service to members of the ISMS. He felt that the Council and/or the House of Delegates should establish a memorial (perhaps a lectureship or a scholarship) and set up a fund so that whatever is selected will be perpetuated in his honor. He suggested that a committee be appointed to study this situation and report back to the Council at the January meeting.

Dr. O'Neill also stated that the president of the Illinois Bar Association had suggested that a special committee be appointed to serve as liaison between the medical society and the bar association as one of the most important fields for closer relationship and co-operation.

He also stressed many fields of activity where

the influence of the medical society could be strengthened and extended — mental health, retarded children, and the research facilities in this field; postgraduate activity in this state; residencies in Illinois for Illinois physicians; the 2,500 physicians in the state who are not members of the ISMS, etc., should all have thought and consideration from the leaders in organized medicine and from a vital and active state society.

Dr. Montgomery stated that the committee to make recommendations for a memorial for Doctor Camp would be: Joseph T. O'Neill, Ottawa, chairman; Harlan English, Danville; Jacob E. Reisch, Springfield.

He also appointed the following committee as Liaison Committee with the Bar Association: William E. Adams, Chicago, chairman; Newton DuPuy, Quincy; Arthur F. Goodyear, Decatur.

It was ruled that Dr. George E. Kirby serve as co-chairman of the Committee on Postgraduate Education as he has during these past years, and that Dr. Julius M. Kowalski of Princeton serve as the representative from the Second Councilor District on the committee.

AD HOC COMMITTEE ON HEADQUARTERS OFFICE

Dr. White, in the absence of Dr. Reavley, chairman of the Ad Hoc Committee on location of headquarters office, reported to the Council, and asked the specific limitations of activity for the committee. The committee was established to determine the city where the office should be located and so to recommend to the House. The actual building where the office will be located will be a matter for the Council to determine when facilities have been found.

MOTION: (Endres-Fullerton) that the Council send "Today's Health" to all members of the state and federal legislatures. Motion carried.

MOTION: (Reisch-Adams) that Mr. Mirt's exhibit be sent to the Kentucky State Medical Association annual meeting September 20-22, 1960. Motion carried.

MOTION: (Fullerton-Portes) that Col. Henry L. Krafft, USA MC, Retired, be elected to membership in the Fifty Year Club. Motion carried.

MOTION: (Fullerton-Piszczek) that membership in the Illinois Chamber of Commerce be renewed for 1960. Cost $200. Motion carried.

MOTION: (Piszczek-Fullerton) that the $10 annual dues in the Advisory Committee on Education in Illinois be paid for 1960. Motion carried.

MOTION: (English-Fullerton) that the action of the Executive Committee in employing Dr. George F. Lull as Secretary-Treasurer be approved. Motion carried.

MOTION: (English-Fullerton) that a letter from Mutual of Omaha be referred to the Committee on Insurance. Motion carried.

COMMITTEE ON POSTGRADUTE MEDICAL EDUCATION

Dr. Limarzi reported as chairman of the Committee on Postgraduate Medical Education and Scientific Service. Since the release of the list of speakers in February 1958, approximately 85 additional names of physicians willing to participate in county medical society programs have been received. It is planned to mimeograph these by category on loose leaf sheets which can be added to our original booklet, and to send them to the program chairmen.

Three requests for postgraduate meetings are on file, but definite information should be forthcoming soon in order that good programs can be prepared.

MOTION: (O'Neill-Goodyear) that the matter of membership in the Interprofessional Council be postponed until the January 31 meeting of the Council. Motion carried.

PUBLIC WELFARE

Dr. Bettag inquired relative to the status of his requests made at the last meeting of the Council — the recommendations to the Governor for appointments to the two commissions, and the action of the Society relative to the proposed bond issue.

He also stated that the Governor would be receptive to suggestions for a replacement for the late Dr. Roland R. Cross as director of the Department of Public Health (a physician trained in public health work, and licensed to practice in Illinois).

Dr. Bettag called the attention of the Society to space available in the Westside Medical Center for office space if the Society were interested in locating in that area.

Dr. Montgomery appointed the following committee to make recommendations to Dr. Lull relative to the recommendation to the Governor for a replacement for Dr. Roland R. Cross: W. W. Fullerton, Sparta, chairman; Caesar Portes, Chicago; Raleigh C. Oldfield, Oak Park.

EMERITUS AND RETIRED MEMBERS

MOTION: (Fullerton-Piszczek) that the physicians be elected to emeritus and retired membership as listed:

EMERITUS: Martin H. Hubrig, Elgin; Joseph Jaffee, Chicago; Anthony J. Linowiecki, Long Beach, Ind. (CMS); Alfred C. Wendt Sr., Chicago.

RETIRED: Leo E. Amtman, Chicago; G. B. Hart, Harrisburg; Ralph F. MacDonald, Chicago; Charles H. Piper, Englewood, Fla. (CMS); Allen L. Sabin, St. Petersburg, Fla. (CMS); Fred F. Schwartz, Miami Beach, Fla. (CMS); Frederick W. Slobe, Chicago; Mary C. Sokolofski, Chicago; James M. Young, Orion.

MOTION: (English-Fullerton) that the bills as will be audited by the Finance Committee be approved. Motion carried.

The Council went into executive session at 2:45 p. m. and arose from executive session at 3:05 p. m.

MOTION: (Fullerton-Piszczek) that actions taken in executive session be approved. Motion carried.

Respectfully submitted,
GEORGE F. LULL, M.D.
Secretary

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SECOND MEETING

The Council gathered for a short meeting following the adjournment sine die of the House of Delegates on Sunday afternoon, December 13, 1959. Only members of the Council were present.

Dr. English stated that he felt the Council should appoint Dr. Theodore R. Van Dellen editor of the Illinois Medical Journal to replace Dr. Camp, and to authorize him to hire whatever assistants he might need to conduct the affairs of the Journal in a manner he feels suitable. Doctor Van Dellen has assured Dr. English that he will serve in this capacity until such time as the Council feels that a suitable replacement has been found.

MOTION: (English-Fullerton) so move. Motion carried.

MOTION: (Reisch-Portes) that the Council appoint a committee to look into the conditions of the hospitals and institutions under the Department of Public Welfare, as well as the care and treatment of patients and subnormal children, and report back to the Committee on Medical Service and Public Relations so that this committee can make a recommendation to the Council relative to the stand to be taken by the Society in regard to the $150 million bond issue requested by the department. Motion carried.

The three members of this committee will be: James H. Hutton, Chicago, chairman; F. Garm Norbury, Jacksonville; Leo P. A. Sweeney, Chicago.

The Council adjourned at approximately 3:00 o'clock.

The next meeting of the Council will be held at the Hotel Sherman, Chicago, on Sunday, January 31, 1960.

Respectfully submitted,
GEORGE F. LULL, M.D.
Secretary

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The AMA Clinical Meeting in Dallas

Freedom of choice of physician, relations between physicians and hospitals, a scholarship program for deserving medical students, and relative value studies of medical services were among the major subjects acted upon by the House of Delegates at the American Medical Association's 13th Clinical Meeting in Dallas, December 1-4.

Speaking at the opening session of the House, Dr. Louis M. Orr of Orlando, Fla., AMA president, urged the nation's physicians to take a more active interest in the whole area of politics, public affairs, and community life. Dr. Orr also asked physicians and medical societies to do a more effective job of telling medicine's positive story, adding that "if more people knew more about the things we support and encourage, they would listen to us much more carefully about those occasional things that we oppose."

Two nationally known political leaders from Texas also addressed the Tuesday morning session. Senator Lyndon B. Johnson, majority leader in the U.S. Senate, called for a "politics of unity" that will enable Americans to exert strength and determination in an effort to create a world in which all men can be free. Speaker of the U.S. House of Representatives, Sam Rayburn, urged greater attention to the task of educating young people in the principles of American government and giving them a desire to perpetuate it.

FREEDOM OF CHOICE

In considering four resolutions concerning free choice of physician, the House reaffirmed the following two statements approved in Atlantic City:

"(1). The AMA believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses.

"(2). Each individual should be accorded the privilege of selecting and changing his physician at will or selecting his preferred system of medical care, and the AMA vigorously supports the right of the individual to choose between these alternatives."

However, in order to clarify and strengthen its position on the issue, the House also adopted this additional statement submitted as a substitute amendment on the floor of the House:

"(3). Lest there be any misinterpretation, we state unequivocally that the AMA firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

PHYSICIAN-HOSPITAL RELATIONS

The House received 12 resolutions on the subject of relationships between physicians and hospitals. To resolve any doubt about its position, the House did not act upon any of the resolutions but instead reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships with Institutions." It also declared that "all subsequent or inconsistent actions are considered superseded."

The House also accepted recommendations that (1) the House of Delegates should acknowledge the need to strengthen relationships with hospitals by action at state and local levels; (2) the Board of Trustees continue to maintain liaison with the Board of Trustees of the American Hospital Association; and (3) the Council on Medical Service review this entire problem to ascertain if there have been actions inconsistent with the 1951 guides.

Those guides summarize the following general principles as a basis for adjusting controversies:

"(1). A physician should not dispose of his professional attainments or services to any hospital, corporation, or lay body by whatever name called or however organized under terms or conditions which permit the sale of the serv-

ices of that physician by such agency for a fee.

"(2). Where a hospital is not selling the services of a physician, the financial arrangement, if any, between the hospital and physician may be placed properly on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching, research, charitable services, or the like. Corporations or other lay bodies may provide such services properly and employ or otherwise engage doctors for those purposes.

"(3). The practice of anesthesiology, pathology, physical medicine, and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine, or any other designated field of medicine."

SCHOLARSHIP PROGAM

To help meet the need for an increasing number of physicians in the future, the House approved the creation of a special study committee which was asked to:

(1). Present a scholarship program, its development, administration, and the role of the AMA in fulfilling it.

(2). Ascertain the maximum to which medical schools could expand their student bodies while maintaining the quality of medical education.

(3). Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching, either on a two year or a full four year basis.

(4). Investigate the securing of competent medical faculties.

(5). Investigate financing of expansion and establishment of medical schools.

(6). Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.

(7). Develop methods of getting well qualified students to undertake the study of medicine.

(8). Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.

The House urged that the special committee be implemented promptly with adequate funds and staff so that it may make an initial report by June 1960.

RELATIVE VALUE STUDIES

Reaffirming a previous policy statement, the House approved in principle the conducting of relative value studies by each state medical society, rather than a nationwide study or a series of regional studies by the AMA. The House also reiterated its authorization for the Committee on Medical Practice to inform each state medical association, through regional or other meetings, of the purpose, scope, and objectives of such studies, the steps to be followed in conducting studies, the problems which may be encountered, and the manner in which the results can be applied.

The House recognized, however, that some state medical societies are either not interested in relative value studies or are actively opposed to them. It pointed out that some state medical associations fear that the regional conferences of the Committee on Medical Practices will put pressure on them to carry out such studies and that this will result in the adoption of fixed fees. Since the regional conferences are educational in nature, the House said, it remains for each state or county medical association to accept or reject the idea of a study in its area.

The House expressed awareness of the fact that this is still a controversial matter. However, it commended the Committee on Medical Practices for its effort to carry out the instructions of the House, and it urged the committee to continue its educational work.

MISCELLANEOUS ACTIONS

In considering 44 resolutions and a large volume of annual, supplementary, and special reports, the House also:

Learned that the AMA Board of Trustees has appointed a liaison committee to meet with a similar committee of the American Osteopathic Association to consider matters of common concern;

Emphasized that local medical societies should insure that no member violates ethical traditions as they relate to ownership of pharmacies or stock in pharmaceutical companies;

Called for investigation of the need, desirability, and feasibility of establishing a home for aged and retired physicians;

Urged active promotion and careful study of the newly developed "Guides for Medical Care in Nursing Homes and Related Facilities";

Suggested that fees for consultative examinations under programs of the Bureau of Old Age

and Survivors Insurance should be adjudicated directly between the state medical society and the state agency involved;

Registered a strong protest to the Veterans Administration, urging stricter screening of nonservice-connected disability patients admitted to government hospitals;

Reiterated the Association's support of the Blue Shield concept and directed the Council on Medical Service to submit at the June 1960 meeting its recommendations concerning a policy statement on AMA relationship with Blue Shield plans;

Suggested that S.J. Res. 41, a bill that would institute a separate program of international medical research, be delayed until an over-all assessment can be made of proposals now before Congress dealing with domestic and international medical research;

Endorsed the program of the Educational Council for Foreign Medical Graduates but also urged that judicious consideration be given to local problems involved in the July 1, 1960, deadline for certification of foreign graduates;

Urged that medical schools include in their curricula a course on the social, political, and economic aspects of medicine.

Declared that the threat of nuclear warfare has imposed a tremendous responsibility on the medical profession, which must be prepared to assume a critically important role in such an event;

Suggested that the AMA make available to school libraries information and literature showing the advantages of private medical care and the American free enterprise system;

Stated that examinations to determine the physical and mental fitness of aircraft crew members should be made by doctors of medicine with special knowledge and proficiency in certain techniques;

Urged the American people to get proper tetanus toxoid, original and booster, and other immunizations as indicated from their physicians, and called on AMA members to co-operate in an educational program on tetanus immunization;

Recommended that all state and county medical societies establish programs for the inspection and testing of all fluoroscopic and radiographic equipment;

Called upon each individual physician to wage "a vigorous, dynamic, and uncompromising fight" against the Forand type of legislation;

Urged state and local medical societies and individual physicians to implement the AMA program for recruitment of high grade medical students;

Accepted with appreciation a $2,500 contribution by Smith, Kline and French Laboratories toward establishment of a suitable award honoring the name of Dr. Thomas G. Hull, retiring secretary of the Council on Scientific Assembly, and

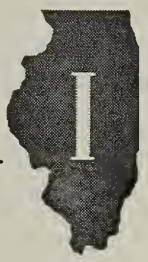
Reaffirmed the "Suggested Guides to Relations Between Medical Societies and Voluntary Health Agencies," adopted at the December 1957 meeting in Philadelphia.

Dr. Chesley M. Martin of Elgin, Okla., was elected the 1959 "General Practitioner of the Year."

The total registration was approximately 4,800, including about 2,800 physicians.

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CORRESPONDENCE



Clinics for crippled children listed for February

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will count seventeen general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing service. There will be two special clinics for children with cardiac conditions, and two for children with rheumatic fever, and one for cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

February 3 — Alton (Rheumatic Fever), Alton Memorial Hospital
February 3 — Centralia, St. Mary's Hospital
February 3 — Hinsdale, Hinsdale Sanitarium
February 3 — Metropolis, Methodist Educational Building
February 4 — Macomb, St. Francis Hospital
February 5 — Chicago Heights (Cardiac), St. James Hospital
February 9 — East St. Louis, St. Mary's Hospital
February 9 — Peoria, Children's Hospital
February 10 — Champaign-Urbana, McKinley Hospital
February 11 — Springfield, St. John's Hospital
February 12 — Evanston, St. Francis Hospital
February 16 — Belleville, St. Elizabeth's Hospital
February 17 — Chicago Heights (General), St. James Hospital
February 18 — Anna, County Hospital District
February 18 — Elmhurst (Cardiac), Memorial Hospital of DuPage County
February 18 — Litchfield, Madison Park School
February 18 — Rockford, St. Anthony's Hospital
February 23 — Effingham (Rheumatic Fever), St. Anthony Hospital
February 23 — Peoria, Children's Hospital
February 24 — Elgin, Sherman Hospital
February 25 — Bloomington a.m. (General), p.m. (Cerebral Palsy), St. Joseph's Hospital

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Civil defense conference

The AMA Council on National Defense will sponsor the 11th Conference of the County Medical Societies Civil Defense Organization on November 5-6, 1960, at the Palmer House in Chicago.

This announcement is made far in advance of

the meeting as the Council would appreciate county medical societies giving publicity to this conference and encouraging them to arrange their budgets so that at least one of their physician representatives might attend. State medical societies are also urged to publicize the conference and send as many representatives as possible.

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PG course in chest diseases

The American College of Chest Physicians will present its annual postgraduate course in diseases of the chest in Philadelphia, March 14-18. It will cover recent advances in the diagnosis and treatment of heart and lung diseases.

Further information may be had by writing to the ACCP, 112 East Chestnut Street, Chicago 11.

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Congress on physical medicine

The third International Congress of Physical Medicine will be held in Washington, August 21-26.

The American Congress of Physical Medicine also announced that two awards will be made for the best papers pertaining to physical medicine and rehabilitation, and one award for the best paper on "Etiology of Decubitus Ulcers."

Further information may be had by writing to the ACPM, 30 North Michigan Avenue, Chicago 2.

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Medico-legal institute

The Law-Medicine Center of Western Reserve University, Cleveland, will offer a two-day institute on "The Back: A Law-Medicine Problem Reappraised," February 12-13. The fee will be $25.

For further information, write to Mr. Oliver Schroeder Jr., Law-Medicine Center, Western Reserve University, Cleveland 6.

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Orthopsychiatric meeting

The American Orthopsychiatric Association will hold its 37th annual meeting at the Sherman Hotel, Chicago, February 25-27.

The program will include joint sessions with the American Public Health Association, World Federation of Mental Health, American Group Psychotherapy Association, Society of Projective Techniques, American College Health Association, and American Association of Psychiatric Clinics for Children.

Further information may be had from the AOA, 1790 Broadway, New York 19.

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Proctology paper contest

The International Academy of Proctology will award $100 and a certificate of merit for the best unpublished contribution on proctology or allied subjects. Entries must be received by February 1.

For further information, write to Dr. Alfred J. Cantor, 147-41 Sanford Avenue, Flushing 55, N. Y.

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Cancer conference planned

"Changing Concepts Concerning Cancer" will be the theme of the 4th National Cancer Conference in Minneapolis, September 13-15, to be sponsored by the American Cancer Society.

Program information may be had by writing to the ACS, Medical Affairs Department, 521 West 57th Street, New York 19.

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Congress on maternal health

"The A B C's of Modern Maternal and Infant Health" will be the theme of the fourth Illinois Congress on Maternal and Infant Health to be held at the Pere Marquette Hotel, Peoria, Ill., February 3-5.

The congress will consist of breakfast and luncheon conferences, round tables, and formal papers. Dr. Robert A. Beebe of Chicago is general chairman, and Dr. Stuart Abel of Chicago is chairman of the program committee.

Programs and registration forms may be obtained from the American Association for Maternal and Infant Health, 116 South Michigan Avenue, Chicago 3.

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Surgeons to meet in Israel

An international conference of surgeons will be held in Tel Aviv and Jerusalem, May 21-23, it was announced by Dr. Max Thorek, Chicago, founder and secretary general of the International College of Surgeons.

The conference will be held under the auspices of the Israeli minister of health and will deal

in particular with medical problems of young nations in Asia and Africa.

For further information, write to the ICS, 1516 Lake Shore Drive, Chicago 10.

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Chicagoan to direct course in nasal surgery

An international course in the fundamentals of reconstructive surgery of the external nasal pyramid and the nasal septum will be presented in Mexico City, July 4-15. It will be under the auspices of the University of Mexico School of Medicine in co-operation with the American Rhinologic Society.

Dr. Maurice H. Cottle, professor of rhinology and otolaryngology at the Chicago Medical School and founder of the American Rhinologic Society, will be the guest professor. Dr. Cottle will be assisted by a faculty of specialists from the United States and Mexico. Applicants must be diplomates of the American Board of Otolaryngology, or have equivalent status.

The ARS, with Dr. Cottle as guest director, also will co-operate in a seminar on "Reconstructive Surgery of the Nasal Septum and External Nasal Pyramid" to be held in New Orleans, February 10-13, under the auspices of the Louisiana State University Medical School's Department of Otolaryngology and the Charity Hospital.

Application forms may be obtained from Dr. Robert M. Hansen, secretary of the ARS, 1735 North Wheeler Avenue, Portland 12, Ore.

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Seminar slides available

The Illinois Society of Pathologists announced that seminar slide sets, consisting of 16 slides of 11 cases, are available at $10 through Dr. James B. Hartney, 410 Lake Street, Oak Park.

AAGP to hold scientific assembly in Philadelphia

The American Academy of General Practice will hold its 12th annual Scientific Assembly in Philadelphia, March 21-24.

The program will include presentations by 31 prominent medical educators, covering a wide variety of subjects. There also will be more than 100 scientific and 300 technical exhibits. Physical examinations will be provided for attending physicians.

AAGP's Congress of Delegates will meet March 19. Dr. John Walsh of Sacramento will be inducted as president on March 23, following which the retiring president, Dr. Fount Richardson of Fayetteville, Ark., will be honored at a reception and dance.

Further information may be had from the AAGP, Volker Boulevard at Brookside, Kansas City 12, Mo.

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TB groups to hold annual meetings in Los Angeles

The National Tuberculosis Association will hold its annual meeting in Los Angeles, May 16-18, in conjunction with the annual meeting of the American Trudeau Society, whose meeting will continue through May 19.

Public health sessions will be held concurrently with medical sessions. In addition to the presentation of papers, there will be five panels and seven luncheon seminars covering various aspects of tuberculosis.

Further information may be obtained from the NTA, 1790 Broadway, New York 19.

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THE P. R. PAGE



John A. Mirt

Medicine takes positive stands

One widely held opinion by the public is that medicine as a profession is opposed to every legislative move it does not institute. This is refuted by the record.

In the first session of the 86th Congress, 13,892 bills were introduced. Of these, the AMA Council on Legislative activities studied 1,000 and analyzed 495. Seventy-seven were subject to legislative activity.

AMA representatives testified at congressional committee hearings or submitted written statements on 19 occasions. In 14 instances, the AMA supported the legislation. On four occasions, the statement was for informational purposes. In only one case, was opposition expressed. That concerned the Forand Bill.

Opposition to Forand Bill

In opposing H. R. 4700 — the Forand Bill — medicine contends that this measure is a clear-cut and direct threat to the private practice of medicine.

The objective of the bill is to provide hospitalization and surgical care to social security beneficiaries. This would add an estimated 12 to 16 million people to the already huge segment of the population covered by some form of socialized medicine. The annual cost of the program may run as high as $2 billion annually, all of which must come out of taxes.

Aside from the added tax burden on the population as a whole, the medical profession contends that the bill is a threat to the high quality of medical care that has made the U. S. one of the healthiest nations in the world.

The measure, if enacted into law, would abridge free choice of physicians. It would mean federal control and bureaucratic interference in medical decisions, and domination of hospital and other health facilities. Responsibility for care of the aged would be shifted from the family and local and state agencies to the national government. The quality of medical care would be reduced. Voluntary health insurance, the instrument of a self-reliant nation, would be imperiled.

For these reasons, the Committee on Medical Service and Public Relations of the ISMS, on instructions from the Council, has carried on an aggressive program to inform every member of the dangers, and to pave the way for a public education campaign.

This public drive should be under way now because Congress is in session again. Although the Republican administration has expressed opposition to the Forand Bill, there is evidence of a softening attitude. A slightly watered-down version is possible unless sufficient public protests are forthcoming.

The arousing of such opposition is the No. 1 item on today's legislative action agenda.

Medical care of the aged

Meanwhile, medicine must carry on vigorously its efforts to provide a high quality of medical care for the aged which is within the means of those 65 or over.

Recently, the ISMS undertook a survey of its members to ascertain what co-operation might be expected in the development of health insurance plans for senior citizens that would meet the problem.

There was a 40 per cent response to the questionnaire, an unusually high figure for a survey. A simpler questionnaire two years ago, covering the scientific and economic phases of the annual meeting, brought replies from only 19 per cent of the members.

Most encouraging was the fact that Illinois physicians, by a ratio of about six to one, said they were willing to go along with a Blue Shield, or similar, type of program that would provide effective prepayment insurance for those 65 or over with modest resources and low family income. It was significant that this support was expressed by physicians in urban and rural areas alike.

This is an important hurdle in medicine's efforts to provide a solution of the problem within the framework of free enterprise. The next step is to obtain similar support from hospitals and ancillary services. This is needed to encourage more prepayment insurance carriers to develop programs for the senior group of citizens.

The future of medical practice depends upon success in that direction.

Medical assistant PR "ambassador"

The key role played by the physician's medical assistant in creating good public relations is emphasized in a new film available for showings to medical societies and medical assistants groups.

Entitled "First Contact," the 26-minute dramatic 16 mm color film shows the mistakes a new office assistant can make unless she is properly trained for her job. The film points out that medical assistants groups provide opportunities for increasing on-the-job efficiency.

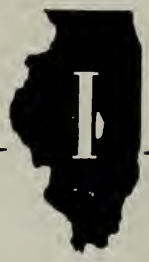
Prints are available to medical societies through the AMA's Department of Medical Motion Pictures and Television, 535 N. Dearborn street, Chicago 10, and to medical assistants groups through the headquarters of the American Association of Medical Assistants, 510 N. Dearborn street, Chicago 10.

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Trigger area

The diagnosis of myofascial syndrome with trigger areas involves physical stimulation of the trigger, consequent reproduction of the pain syndrome, and subsequent relief by block of the trigger area with a local anesthetic drug. The examiner's finger, a reflex hammer, ultrasound, a needle used for probing, or other similar measures will serve to locate the trigger area or areas. These are very small, usually a centimeter or less in diameter and sometimes only a millimeter or two in diameter. *Karl W. Erwin, M.D. Myofascial Syndrome with Trigger Mechanisms. Texas J. M. Sept. 1959.*

AT THE EDITOR'S DESK



Beer can opener surgery

A two page telegram (leased wire) from a Cincinnati conference quoted the New York cardiologist, Joseph T. Roberts, as saying that common household articles could save many lives especially during an emergency or disaster. On blood vessel surgery he states "A can opener, razor blade, or nail file can be used to make the incision and the artery can be picked up with eyebrow tweezers. Bobby pins, paper clips, rubber bands, or clothes pins make excellent clamps to stop the flow of blood." He has connected several blood vessels of animals using beer can openers and eyelash curlers also.

Dr. Timothy Takaro told the same group that blood vessels may now be stapled like sheets of paper, with a new machine.

Science is wonderful. A new machine to staple blood vessels shares headlines with common household articles that now are recommended to replace modern surgical equipment.

A new gimmick

A scientific apparatus company in Albuquerque, New Mexico, recently advertised in a Chicago newspaper a free book on reducing. Since the product was free and there appeared to be no strings attached to the offer we wondered what the gimmick might be. My secretary agreed to be the guinea pig and sent a request for the book to the advertiser.

A small 16 page booklet, "Metabolism and Glandular Functions," arrived. It contained the usual advice on reducing along with a few subtle but innocent recommendations. Increasing the metabolic rate was the key to weight reduction. Reducing salons, massage, and steam baths were condemned. The brochure stressed the need for consulting a doctor who specialized in overweight reduction. It said, "there are many physicians who are not interested in the problems of weight reduction and prefer a general practice or some other specialty." Some headings included, "How a doctor can help you reduce" and "Don't be afraid to go to a doctor." The conclusion: "the best, safest, and least expensive way to eliminate your excess weight is to go to a doctor in, near, or close to your own home town, who devotes a considerable portion of his practice to the specialty of weight reduction."

Still no gimmick. Two weeks later the following card arrived

Special Attention Given to the
Reduction and Control of
Overweight
Dr. Drake R. A. Witty
Physician & Surgeon
10938 South Western Ave.
Chicago 43, Illinois
Telephone: BEverly 8-2540
Hours by appointment

Dr. Witty is an osteopath. With the card was a folder, "General Instruction to Overweight Patients." Treatment, as described, includes "a gland and digestive medication" which the individual receives with each monthly checkup.

The gimmick — a name and address of an osteopath who co-operates and uses a certain medication that probably is brewed in New Mexico.

Faulty trailer heater

The Public Health Service warned owners of mobile houses to beware of a small bottled gas heater that has caused eight or more deaths recently. It is the Thurm Heater, a wall panel unit that has a faulty design and is capable of building up lethal concentrations of carbon monoxide within a small trailer in a short time. The model number is 8M or 8MNS, but it is also possible that this identification may not be on the heater.

Glogg

Every town and district in Norway has a Sobriety Board that co-ordinates problems related to alcohol. The local group advises the authorities on the sale and serving of drinks and makes an annual report on its work along with conditions concerning alcohol consumption and alcoholism in the district.

But the responsibilities are broader than comparable liquor boards or commissions in this country. It co-operates with local schools concerning education about alcohol. Talks and symposiums are arranged for adults. The Board also is responsible for the treatment of the alcoholic on the recommendation of the family or the physician. It has much power in this respect and intervenes when necessary in order to examine a case thoroughly. The alcoholic is encouraged to change his ways and induced to consent to treatment. If he agrees, he signs a paper to this effect. He is not forced to do this yet the board has the power to make treatment mandatory after consulting with the local judge. The medical director has the final word on whether the alcoholic is sent to a rehabilitation center or to an institution.

The plan has many advantages but must be resented by the alcoholic, especially in smaller communities. The members of the board are in a position to watch their charges with the eagle eye of a G man, or the fervor of a Carrie Nation. This may explain why 60 to 70 per cent of the alcoholics in Norway live in and about Oslo. Perhaps they migrate into the capital to be lost in the crowds away from the watchful eyes of the Sobriety Board.

Family practice program

"A two-year intensive educational program for young physicians aspiring to the role of family doctor and desiring more clinical experience than a routine hospital internship has been developed by the Indiana University School of Medicine. The new family practice program follows suggestions of the AMA and the American Academy of General Practice for such training but differs from any similar programs now offered."

According to Dr. W. Donald Close, "it aims to provide a more intensive background of experience for the trainee in the diagnostic and treatment problems he will encounter among patients of all ages when he establishes his own office." The trainee will receive a special orientation in emergency room, medicine, pediatric, psychiatric, and obstetric services at the start of the two-year program.

Pharmaceuticals

Declomycin, Lederle's new antibiotic, was reported by Dr. Guillermo Chavez Max of Mexico City to be of value against brucellosis. It was used on nine patients who became free of any signs of the illness in two and a half months. Control studies will be needed before these results can be duplicated.

Pfizer, in a news release, claims that an intramuscular injection of Terramycin cured 62 of 67 cases of acute gonorrhea in Haiti. A 500 mg. dose was given in two simultaneous injections.

The Medical Letter on Drugs and Therapeutics reports that "Deprol (Wallace) is of no value for the treatment of either neurotic or psychotic depression."

The drug is a combination of benactyzine and meprobamate (Miltown). In the opinion of the group, many of the claims for benactyzine, an anticholinergic drug, have not been demonstrated by controlled trials. It is not effective against phobias, depression, agitation, or anxiety.

The letter states also that meprobamate has not been shown to possess antidepressant properties despite claims based on uncontrolled clinical impressions. It has sedative effects similar to those of the barbiturates, along with unwanted side effects. This group concludes, "the chief danger in the promotion of this drug (Deprol) is that it will be given to seriously depressed patients and that valuable time will be lost before effective treatment is instituted."

NEWS of the STATE



COOK

Citation. Dr. James H. Hutton was honored for 25 years of leadership in a continuing fight to eradicate tuberculosis in Illinois. He received a citation presented by Dr. George C. Turner at a luncheon sponsored by the Chicago Medical Society and the Tuberculosis Institute of Chicago and Cook County on December 10.

Lectures. Dr. Joseph B. Kirsner, professor of medicine, University of Chicago, spoke to the Ileoptimists, Inc. of Chicago on "The Nature of Ulcerative Colitis," December 28.

February lectures for the International College of Surgeons will be: February 2, "Highlights of Orthopedic Surgery," by Dr. Philip Lewin, professor emeritus of orthopedic surgery, Northwestern University; and February 23, "The Bookplates of Physicians," by Dr. Morris Fishbein, professor emeritus of medicine, University of Chicago and University of Illinois. These talks are given at 8 p.m., Hall of Fame, 1524 Lake Shore Drive, Chicago.

February lectures for the series of Northwestern University Medical School will be: February 2, "They Were Also Patients: George Gershwin, Clarence Darrow, and Adolf Hitler," by Dr. Noah Fabricant, associate editor, Ear, Eye, Nose, and Throat Monthly; February 9, "The Medical Revolution," by Dr. Lester King, clinical professor of pathology, University of Illinois College of Medicine; February 16, "The History of Vascular Surgery," by Dr. William S. Dye, clinical associate professor of surgery, University of Illinois College of Medicine; and February 23, "Medical Illustrations," by Mr. Thomas Jones, professor emeritus of medical and dental illustrations, University of Illinois College of Medicine. The talks are given at 8 a.m. in room 641, Northwestern University Medical School, 303 E. Chicago Ave., Chicago.

Dr. Maurice H. Cottle, professor of rhinology and otolaryngology, Chicago Medical School, gave a series of lectures and surgical seminars on nasal and septum surgery at the University of North Carolina School of Medicine recently.

Dr. T. R. Van Dellen spoke on "The Physician Needs Help," at the second annual symposium of the Educational Committee of the Chicago Medical Assistants Association recently.

Dr. C. Knight Aldrich, professor and chairman department of psychiatry, University of Chicago, will discuss "Diagnosis, Prognosis and Hope: New Trends in Restoring Mental Health," February 2, at St. Paul Community Church, 18200 Dixie Highway, Homewood. This is one of the mental health talks sponsored by South Cook Section of the National Council of Jewish Women and the Mental Health Society of Greater Chicago, Inc.

Chicago Society December Meetings. At the meeting of the Chicago Urological Society, Dr. Robert A. Garrett, professor and chairman, department of urology, Indiana University School of Medicine, spoke on "Cineurography."

The program for the Chicago Society of Internal Medicine was: "The Problem of Streptococcal Immunity in Rheumatic Fever Prevention," by Dr. Gene H. Stollerman, associate professor of medicine, Northwestern University Medical School; and "Irreversible Heart Disease Due to Chronic Nonspecific Myocarditis," by Dr. Earl N. Silber, clinical assistant professor of medicine, Chicago Medical School.

Dr. Lester S. King, clinical professor of pathology, University of Illinois spoke on "The Decline and Fall of Bloodletting," and Dr. Noah D. Fabricant, associate editor, Eye, Ear, Nose, and Throat Monthly spoke on "The Medical History of Adolf Hitler," at the meeting of the Society of Medical History of Chicago.

Chicago Neurological Society had the following program at their meeting: "Current Concepts in Neuropathology," by Orville T. Bailey; "Latest Advances in Neurophysiology," by Arthur Kling; and "Recent Advances in the Study of Brain," by Erminio Costa.

The program of the Chicago Surgical Society was: "Bilateral Radical Neck Dissection," by Charles J. Staley, Edward F. Scanlon (discussion — Harry W. Southwick); "Cancer of the Breast in Rockford, Illinois," by Alfred C. Meyer; "Intermittent Claudication," by Geza de Takats, William H. Harridge, and John D. Griffiths; and "Revascularization of the Heart — A Comparative Study," by Frances Knock and Edward J. Beattie.

The Chicago Gynecological Society had the following program at their December meeting: "Protein Excretion Patterns in Pregnancy," by Drs. A. B. Lorincz and C. P. McCartney, and Messrs. R. E. Pottinger and K. H. Li; "Human Cervical Epithelial Changes Produced by Podophyllin," by Dr. Harold A. Kaminetsky.

Change of Address. The Board of Directors of the Municipal Tuberculosis Sanitarium, announced that their clinic services are discontinued in Provident Hospital. Their new address is 3525 South Michigan Avenue, designated as the Ernest E. Irons Clinic in memory of the late president of the Board. Dr. E. Lee Strohl, senior attending surgeon at Presbyterian-St. Luke's Hospital and attending surgeon at Cook County Hospital, is now president of the Board.

Appointments. Dr. Arkell M. Vaughn, professor of surgery, Loyola University, was installed as president of the Mississippi Valley Medical Society.

Dr. Willis J. Potts, pediatric surgeon at Children's Memorial Hospital, is the new president of the Chicago Heart Association. He succeeds Dr. Wright R. Adams, chairman of the department of medicine, University of Chicago.

Woman's Auxiliary. Mr. Walter L. Oblinger, associate counsel for ISMS, spoke at the January meeting of the Woman's Auxiliary to the Chicago Medical Society on the Forand bill.

FULTON

Meeting. Attorney Albert Scott spoke on "The Forand Bill" at the December meeting of the Fulton County Medical Society.

GREENE

Meeting. The Greene County Medical Society held its December meeting jointly with the Southwestern Bar Association.

LAKE

Meeting. The December meeting for Lake County Medical Society held election of officers. In November the society sponsored the Sports Injury Clinic, which was designed for administrators, coaches, and trainers in the contact sports. Dr. Gerrit Dangremond was chairman of the clinic.

PEORIA

Meeting. The Peoria Medical Society held its annual business meeting in December.

ROCK ISLAND

Meeting. Rock Island County Medical Society held its annual business meeting in December.

ST. CLAIR

Meeting. The St. Clair County Medical Society held a business meeting in December.

SANGAMON

Meeting. K. T. Bretscher, investment dealer spoke on "Bargains for Investors?" at the December meeting of the Sangamon County Medical Society.

TAZEWELL

The Tazewell County Medical Society and its

Woman's Auxiliary were honored with the presence of Senator and Mrs. Everett M. Dirksen, Representative and Mrs. Robert Michel, and Mayor Norman Shade of Pekin, Illinois at their meeting on December 9th at the Isolina Motel in Pekin. The program was arranged by Dr. R. E. Dunlevy, Chairman, Legislation.

Dr. Ralph N. Redmond, of Sterling, Illinois, Councilor of the second district of the I.S.M.S., addressed the group on "Problems of the Aging, and the Forand Bill."

Dr. Lawrence J. Rossi, of Hopedale, Illinois and Mr. Allen M. Hicks, Administrator of Pekin Public Hospital, reported on their studies of "Care of the Aged at the Local Level."

Senator Dirksen, in his address, indicated that the Forand Bill will be difficult to defeat in an election year, but he expressed his belief that if enough physicians discussed the Bill with their patients, as they did in combating the Wagner-Murray-Dingell Bill, it could be defeated.

Installation of the officers for 1960 included: Dr. L. J. Rossi, Hopedale, President; Dr. R. G. Rhoades, Pekin, Vice President; and Dr. D. O. Manshardt, Pekin, Secretary-Treasurer.

VERMILION

Meeting. A film strip and talk — "Time of Decision" given by Dr. Louis M. Orr, president of the AMA at the December meeting of the Vermilion County Medical Society.

GENERAL

Olympic Winter Games. The VIII Olympic winter games will take place at Squaw, California, February 18 to 28. The medical division of the Olympic organizing committee is under the direction of Dr. William W. Stiles, professor of public health at the University of California.

New Officer. Dr. Herman Josephy, Chicago neuropathologist with the American Academy for Cerebral Palsy brain registry, is vice president of that organization for the coming year.

Talk. Dr. T. R. Van Dellen spoke on "Newspaper Medicine," at the Nueces County Medical Society postgraduate seminar in Corpus Christi, Texas recently.

Heads Medical Unit. Dr. Walter H. Theobald was re-elected to his 14th consecutive one year term as president of the Medical Center commission, Chicago. Dr. Theobald is emeritus professor of otolaryngology at the University of Illinois College of Medicine.

State Projects. There is to be a residence and school quarters for the Psychiatric Nurses Training School at Jacksonville State Hospital in the near future. Governor William G. Stratton said that the school is one of five affiliation programs conducted by the Department of Public Welfare in the training of professional nurses. About 360 students per year, out of between 1,200 to 1,400 students in the state, are trained in Jacksonville. In addition to Jacksonville there are affiliate schools of psychiatric nursing training at Chicago State Hospital, Peoria, Anna, and Elgin State Hospitals. With these facilities it is unnecessary for students to leave the state for training, the governor reported.

Honored. The President appointed Dr. T. R. Van Dellen to the Board of Regents of the National Library of Medicine for a 4 year term (until 1963). These appointments are made by and with advice and consent of the Senate. The bill for appropriations for the construction of this new library was signed by President Eisenhower Aug. 1, 1958 and ground was broken on June 12, 1959. A 10 acre tract on the National Institutes of Health reservation at Bethesda, Maryland, has been set aside for this library. Expected date of completion is June of 1961.

Lectures Arranged Through the Illinois State Medical Society

Julius Aronow, assistant professor of pediatrics, Chicago Medical School, the Grover Cleveland School Parent Teacher Association, January 21, on "Immunization."

Coye C. Mason, clinical associate professor of pathology, University of Illinois College of Medicine, Vermilion County Medical Society in Danville, February 2, on "Discriminative Hemotherapy."

Walter L. Palmer, Richard T. Crane professor of medicine, University of Chicago School of Medicine, DuPage County Medical Society in Wheaton, February 17, on "Therapy in Peptic Ulcer, Particularly X-Ray Therapy."

Harley E. Cluxton, Jr., associate in medicine, Northwestern University Medical School, Stephenson County Medical Society in Freeport, February 18, on "Diabetes."

F. Garm Norbury, Medical Director, Norbury Sanatorium, Jacksonville, Logan County

Medical Society in Lincoln, February 18, on "Psychosomatic Medicine."

Nicholas W. Fugo, assistant professor of obstetrics and gynecology, University of Chicago School of Medicine, Stock Yards Branch of the Chicago Medical Society, February 19, on "Teen Age Problems of the Menses."

DEATHS

Albert Butterman*, Chicago, who graduated at Rush Medical College in 1921, died November 16, aged 67.

Roland R. Cross*, Springfield, Director of the Illinois Department of Public Health since 1940, died November 28, aged 71. A 1912 graduate of the National University of Arts and Sciences Medical Department, St. Louis, he was a physician for six years for the Indian Affairs Service. In the Army Medical Corps in World War I, he served as a member of the army's medical board of review. In 1933 he joined the Illinois Department of Public Health as southern Illinois district superintendent. Except for the period from the close of World War I until 1933, when he was engaged in private medical practice in Dahlgren, Ill., he devoted his entire professional career to public service.

William R. Cubbins*, Dundee, who graduated at Northwestern University Medical School in 1900, died November 15, aged 85. He was a former faculty member of Northwestern University, and at one time president of the University's alumni association. He was a founder of the American College of Surgeons, chief of the surgical staff of Cook County Hospital for 12 years, and later a member of the staffs of Wesley Memorial and St. Luke's Hospitals.

Walter C. Frick, Braidwood, who graduated at Jenner Medical College in 1908, died November 23, aged 78. He was a former mayor of Braidwood and a past president of the Reed-Custer high school board.

Werner K. Gottstein*, Chicago, 65, who graduated at Friedrich Wilhelms Universitat Medizinische Fakultat, Berlin, Prussia, in 1921, died November 22, in Presbyterian—St. Luke's Hospital as a result of injuries he received when he was struck by an automobile on August 20 near Hyannis, Mass., where he was vacationing. He was clinical assistant professor of pediatrics at the University of Illinois College of Medicine, consulting pediatrician at Jackson Park Hospital, and formerly a member of the staff of La-Rabida Sanitarium.

John T. Hart*, Chicago, who graduated at the University of Tennessee College of Medicine, Memphis, in 1923, died April 30, aged 64. He was a member of the American College of Surgeons.

Paul B. Kionka*, Melrose Park, who graduated at Bennett Medical College in 1893, died November 9, aged 88.

Louis Simeon Lippman*, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1911, died September 1, aged 79.

Ralph J. Major*, Momence, who graduated at Loyola University School of Medicine in 1933, died November 19, aged 51. He was a physician in Kankakee County for 24 years and formerly practiced in Wheaton.

Ross T. McIntire*, Chicago, who graduated at Willamette University, Medical Department, Salem, Ore., in 1912, died December 8, aged 70. Since 1955 he had been executive director of the International College of Surgeons. He was wartime surgeon general of the Navy and a retired vice-admiral; he served as personal physician to the late President Franklin D. Roosevelt and earlier had specialized in the field of otolaryngology.

Jesse H. McIntosh*, Arcadia, Mo., member of Madison County Medical Society, who graduated at Barnes Medical College, St. Louis, in 1895, died November 10, aged 87.

Harry Price Morgan, Wood River, who graduated at Bennett College of Eclectic Medicine and Surgery in 1906, died August 14, aged 78.

Harris A. Newell, retired, Chicago, who graduated at Northwestern University Medical School in 1909, died November 24, aged 80.

Sylvan H. Robertson*, Highland Park, who graduated at Rush Medical College in 1933, died December 7, aged 53. He was certified by the American Board of Internal Medicine, and had served for many years as a member of the staff of the Highland Park Hospital.

Vincent A. Simkus*, Chicago, who graduated at Loyola University School of Medicine in 1919, died September 12, aged 74.

John J. Toth*, Chebanse, who graduated at

*Indicates members of the Illinois State Medical Society.

Chicago Medical School in 1944, died December 7, aged 50. He had practiced medicine in Iroquois and Kankakee Counties for the last 15 years.

VERNON C. TURNER*, Evanston, who graduated at University of Oregon Medical School, Portland, Ore., in 1936, died November 21, aged 52. He was associate professor of orthopedic surgery at Northwestern University Medical School, chairman of the department of orthopedics at Evanston Hospital, and a fellow of the American and International Colleges of Surgeons.

*Indicates member of the Illinois State Medical Society.

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Your 1960

Annual Meeting

Chicago

May 24, 25, 26, 27

IN EPILEPSY... PREREQUISITE FOR PARTICIPATION: THERAPY

With the use of medications, epileptic students may be enabled to participate in many of the same activities as other students.[1]

REQUISITE FOR THERAPY: THE PARKE-DAVIS FAMILY OF ANTICONVULSANTS

effective anticonvulsants for most clinical needs

for control of grand mal and psychomotor seizures

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KAPSEALS® "In the last 15 years several new anticonvulsant agents have come into clinical use but they have not replaced diphenylhydantoin [DILANTIN] as the most effective single agent for a variety of reasons. Most of them are less effective in control of seizures, have a greater sedative effect and higher incidence of sensitivity reactions."[2]

A drug of choice for control of grand mal and psychomotor seizures, DILANTIN sodium (diphenylhydantoin sodium, Parke-Davis) is available in several forms, including Kapseals of 0.03 Gm. and 0.1 Gm. supplied in bottles of 100 and 1,000.

Phelantin®

KAPSEALS When it has been demonstrated that the combination of Dilantin and phenobarbital is helpful in a patient and that these drugs are well tolerated, the use of PHELANTIN, a capsule providing both drugs, is often a great morale builder because it enables the physician to reduce the total number of pills or capsules the patient is required to take. It is less expensive medication and it prevents the patient from manipulating the dosage.[3] PHELANTIN also contains methamphetamine (desoxyephedrine) to minimize the sedative effect of phenobarbital.

PHELANTIN Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.) are available in bottles of 100.

for the petit mal triad

Milontin®

KAPSEALS • SUSPENSION MILONTIN is one of the most effective agents for the treatment of petit mal epilepsy. Relatively free from untoward side effects, MILONTIN successfully reduces both the number and severity of petit mal attacks without increasing the frequency or severity of grand mal attacks in those patients with combined petit mal and grand mal epilepsy. Also, MILONTIN is considered an excellent choice for initiating therapy in untreated patients.[4-6]

MILONTIN Kapseals (phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000. Suspension, 250 mg. per 4 cc., 16-ounce bottles.

Celontin®

KAPSEALS CELONTIN is effective in the treatment of petit mal and psychomotor epilepsy. It provides effective control with a minimum of side effects, frequently checks seizures in patients refractory to other anticonvulsant medications, and does not tend to precipitate grand mal attacks in those patients with combined petit mal and grand mal seizures. For this reason, CELONTIN is useful in treating patients with more than one type of seizure and can be given in combination with Dilantin.[7-10]

CELONTIN Kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100.

bibliography: (1) Green, J. R., & Steelman, H. F.: Epileptic Seizures, Boltimore, Williams & Wilkins Company, 1956, p. 136. (2) Broy, P. F.: *Pediatrics* **23**:151, 1959. (3) Davidson, D. T., Jr., in Conn, H. F.: Current Therapy 1959, Philadelphio, W. B. Saunders Company, 1959, p. 512. (4) Smith, B., & Forster, F. M.: *Neurology* **4**:137, 1954. (5) Zimmerman, F. T.: *New York J. Med.* **55**:2338, 1955. (6) Lemere, F.: *Northwest Med.* **53**:482, 1954. (7) Perlstein, M. A.: *Pediat. Clin. North America:* **4**:1079 (Nov.) 1957. (8) Livingston, S., & Pauli, L.: *Pediatrics* **19**:614, 1957. (9) Carter, C. H., & Moley, M. C.: *Neurology* **7**:483, 1957. (10) Keith, H. M., & Rushton, J. G.: *Proc. Staff Meet. Mayo Clin.* **33**:105, 1958.

The Month in Washington



Washington, D. C.—Congress embarked on a crucial election year session with expansion of the social security program shaping up as one of the major issues.

It was virtually a foregone conclusion that some liberalization of the program would be voted in the Democratic-controlled congress, but the key question was how far the changes would go. In every presidential election year during recent years, the House and Senate have approved a broadening of the program.

One of the prime reasons social security has been an election year favorite is that the program can be boosted without affecting the federal budget. This is because it is financed through employer-employee contributions and is theoretically self-supporting.

Of special interest to physicians, of course, is the fate of the so-called Forand bill that would provide hospitalization, surgical services, and nursing home care for social security beneficiaries. This would be accomplished through even higher taxes on employees and employers than now scheduled through already-voted step increases.

Supporters of the controversial legislation—vigorously opposed by the administration, the American Medical Association, and allied organizations—launched their move to win enactment this session.

Sen. Pat McNamara, (D., Mich.), whose Senate Subcommittee on Aging held a series of hearings across the country during the recess, announced at the conclusion of the hearings that they showed a need for expanding social security to include health care for the aged. He indicated he thought the Forand bill did not go far enough.

A battery of speakers at a meeting here of the American Public Welfare Association also urged a sharp increase in benefits, with some advocating "cradle to grave" security for all.

Not all of the proposals for extending the program involved health care.

The administration indicated it would recommend some expansion, especially in the disability program under which the federal government helps the states provide assistance to persons over age 50 judged to be totally and permanently disabled. An influential lawmaker, Rep. Burr Harrison (D., Va.), disclosed that he would introduce legislation to remove the age 50 limitation to allow all persons, regardless of age, to participate. He estimated this would not require any hiking of the taxes. Rep. Harrison is chairman of a House Ways and Means Subcommittee that held recess hearings on administration of the disability program.

Meanwhile, Chairman Wilbur Mills (D., Ark.) of the full Ways and Means Committee cleared the way for full-scale hearings this congressional session on the entire issue of social security. In listing specific phases to be considered, however, the lawmaker did not mention the Forand proposal.

(*Continued on page 38*)

A single 5 mg. tablet once a day provides all these advantages[2]

- prolonged action — in excess of 18 hours
- convenient once-a-day dosage
- low daily dosage — more economical for the patient
- no significant alteration in normal electrolyte excretion pattern
- repetitively effective as a diuretic and antihypertensive
- greater potency mg. for mg.—more than 100 times as potent as chlorothiazide
- potency maintained with continued administration
- low toxicity — few side effects — low salt diets not necessary
- comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day
- in hypertension, Naturetin, alone or in combination with other antihypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

Naturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, in the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs (certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb Rauwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

Contraindications: none, except in complete renal shutdown.

Precautions: when Naturetin is added to an antihypertensive regimen including hydralazine, veratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all preparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous drop in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin regimen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on digitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those predisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs—leg or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

Naturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the morning; to initiate therapy, up to 20 mg., once daily or in divided doses; for maintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested initial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending on the individual response of the patient. When Naturetin is added to an antihypertensive regimen with other agents, lower maintenance doses of each drug should be used.

Naturētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

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WASHINGTON (Continued)

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Dr. Eugene F. Hoffman, co-chairman of the AMA's Physician's Advisory Committee on Television, Radio, and Motion Pictures, declared "the medical profession stands ready to assist the networks and individual stations in determining accuracy and good taste of broadcast material involving health or medicine—either commercial or public service."

‹ ›

History

We notice that doctors seldom mention the amanuensis without a particular qualifying adjective. This is true whether one speaks of history-taking in the abstract or as applied to a particular patient. It seems that the history is always careful just as the martini is always dry. *Editorial. The Careful History and the Dry Martini. Pennsylvania M.J. May 1959.*



You can't read latin? Then how do you know I'm a poor writer?



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Weighing side effects

The initial worry about side effects from griseofulvin, such as decrease in the count and mobility of sperm, which were observed when the medicament was given parenterally and not orally to experimental animals, has not been supported by extensive clinical observations and pertinent laboratory studies in many male patients in several clinics. A rebound effect seems to be the rule in that as the drug is withdrawn the count rises appreciably and some of our patients have actually noted an increase in their libido and potentia. It is suggested that complete blood counts be performed at two-week intervals during therapy.

Some patients have complained of feeling lightheaded and others have had heartburn, nausea, epigastric distress, or diarrhea, all of which were mild and which stopped on decreasing the dosage. Specific observations to see whether or not patients sensitive to the widely used penicillin obtained from P. notatum might show cross sensitivity reactions have been made and none has been seen. Transistory skin reactions and urticaria have been observed. *Sture Johnson, M.D. Griseofulvin, a New Drug for the Oral Treatment of Superficial Fungus Diseases. Wisconsin M.J. Sept. 1959.*

‹ ›

Aortic aneurysm treatment

It is now commonly agreed that the treatment of aortic aneurysms consists of excision of the diseased segment with replacement by either human or prosthetic graft. Whether such a procedure may be successfully carried out depends upon a reasonable selection of patients. In the patient with a recent coronary occlusion or in patients with severe renal disease, it would be unwise to suggest operation. It is well known, however, that patients with healed infarcts tolerate major operations well. It is generally conceded that any patient who is in reasonably good physical condition and who has an aortic aneurysm should have excision and graft replacement. *M. Nazih Zuhdi, M.D.; John M. Carey, M.D.; and Allen E. Greer, M.D. Aneurysms of the Aorta. J. Oklahoma M.A. Sept. 1959.*

oral METRAZOL
reactivates the geriatric patient

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reactivates the convalescent

oral METRAZOL
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— for those patients who need additional vitamins —

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Each teaspoonful, 100 mg. METRAZOL, 10 mg. niacinamide, 1 mg. each of thiamine, riboflavin, pyridoxine, and 2 mg. d-panthenol. Each tablet, in addition, 25 mg. vitamin C.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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Psychiatric consultation

Not infrequently physicians destroy the treatment before the patient ever gets to the psychiatrist. This is done in the manner in which the initial referral is made. Referrals to the psychiatrist should be made in a positive, open, and constructive way, just as are referrals to any other specialist. Too often the physician apologizes for suggesting that the patient see a psychiatrist. Another negative approach is the deceptive or dishonest maneuver in which the physician tells the patient he is going to send him to a "nerve specialist" or to a "neurologist." Such a revelation of insecurity on the part of the physician is scarcely calculated to instill confidence in the patient.

Physicians are human beings with the same conflicts, defects, faults, and frailties that exist in other human beings. They are therefore subject to making mistakes, often catalyzed by unconscious factors. The conscientious physician readily accepts the fact that he needs to continue to learn. He continues to gain satisfaction through learning and thereby enriches his experiences and his life. All physicians want to help their patients and yet we all sometimes unwittingly do things that are not in the patient's best interest. *Carl L. Kline, M.D. Iatrogenic Sabotage of Psychotherapy. Wisconsin M.J. Aug. 1959.*

‹ ›

A debtor is not an investor

"A voice from the rear seat broke into this revery. Harry wanted to know was I interested in mutual funds. 'Get you six per cent against three at the savings banks.' Told him I wasn't interested. Harry and the others may think I'm in the chips, but what they don't know is that I owe $2,400 on my car, $450 on Janie's orthodonture, about $300 in odds and ends, including the new freezer (not counting mortgage payments, insurance, taxes, and it hurts my head to even try to remember all the rest). Even if I took all my savings and invested them at six per cent, the annual return wouldn't be enough to keep my boy Timmie (my 11 year old) in model airplane engines. Big financier!" *Master Your Tensions and Enjoy Living Again. George S. Stevenson, M.D. and Harry Milt. Englewood Cliffs, N.J., Prentice-Hall Inc., 1959.*



Peptic ulcer and blood pepsinogen

The fact that an increase in gastric secretion is associated with the presence of a duodenal ulcer does not mean that the former is responsible for the latter, or vice versa. Thus, patients with duodenal ulcer may show the same high rate of gastric secretion during asymptomatic intervals, when the lesion has healed, as they do during exacerbations when the lesion is active. Likewise, the high concentration of pepsinogen in the serum or the high rate of pepsinogen excretion in the urine persists even after the duodenal lesion has healed. Such observations suggest that gastric hypersecretion is an essential but not the sole determinant in the etiology of duodenal ulcer. Rather than being an immediate causative factor, gastric hypersecretion may be a predisposing factor. *I. Arthur Mirsky, M.D. Physiologic, Psychologic, and Social Determinants in the Etiology of Duodenal Ulcer. Am. J. Digest Dis. April 1958.*

‹ ›

Anything will give up its secrets if you love it enough. — *Dr. George Washington Carver*

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meprobamate *plus* d-amphetamine

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Dosage: One tablet one-half to one hour before each meal.

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upgrade low-grade protein—cereals and other low protein favorites of children, upgraded by l-Lysine, work with meat and other top protein to build stronger bodies.

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Vitamin B_{12} Crystalline	25 mcgm.
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Ferric Pyrophosphate (Soluble)	250 mg.
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Sorbitol	3.5 Gm.
Alcohol	0.75%

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BOOK REVIEWS



THE DIABETIC'S HANDBOOK. Anthony M. Sindoni, Jr., M.D. 2nd ed. $4.50. Pp. 285. New York, Roland Press, 1959.

The first edition of this layman's manual, published in 1948, has been revised and brought up to date. The 18 contributors are physicians at the Philadelphia medical schools. In plain language, the book presents scientific reasoning regarding the nature and treatment of diabetes. The first 54 pages answer more than 200 questions commonly asked by diabetics. This section will be useful in supplementing the physician's advice. The pathology and physiology underlying symptoms and complications are explained in simple terms, indicating cause and effect relationships. Only a few elementary diagrams are included and photographs are lacking. Special problems of diabetes in adulthood and childhood are indicated briefly with valuable paragraphs regarding emotional stress.

The technique of insulin administration is described with sketches, and there is a short section mentioning the oral insulin substitutes. Some authorities would argue with the author's concept that teaching these patients household measure system is simpler and more desirable than the weighed and estimated dietary system. The food exchange system advised by the American Diabetes Association is utilized, including menus with both the metric and a household equivalents. Tables giving symptoms of vitamin deficiency and fuel values of alcoholic beverages seem somewhat extraneous though they, as well as the tables of food composition, might prove useful for reference purposes. Certain laboratory tests for checking the urine are outlined at the end of the book. No distinction is made between the less accurate screening tests for urinary glucose and the more accurate quantitative tests. Descriptions of the popular examinations for sugar and acetone, utilizing tablets (Ames Company, Inc.), is lacking.

This handbook is particularly recommended for patients with recently discovered diabetes. It constitutes a supplementary method of instruction in the elementary concepts of the disease.

A.R.C. Jr.

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CLINICAL AUSCULTATION OF THE HEART. By Samuel A. Levine and W. Proctor Harvey. 2nd edition. Philadelphia, W. B. Saunders Company, 1959. Pp. 657; illustrations 660. $11.00.

As in the first edition published a decade ago, this revision shows how conveniently and inexpensively—by means of the simple stethoscope—the physician can make diagnoses in certain instances, suggest diagnoses to be confirmed by further studies in others, and evade certain diagnostic pitfalls that may be decisive in matters of

(*Continued on page 72*)

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- Does not destroy normal intestinal flora nor encourage monilial overgrowth (little or no fecal excretion)

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Average adult dose: 250 mg. four times a day, with food or milk
Pediatric dosage: 22-25 mg./Kg. (10-11.5 mg./lb. body weight daily in 4 divided doses

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depresses appetite and elevates mood

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eases tensions of dieting
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BOOK REVIEWS (Continued)

life and death. Studying this book will benefit not only students but also a great many specialists in cardiology who fail to apply the information obtainable from auscultation.

This new edition might be termed a mixed blessing. Doubled in volume of text and illustrative material, the book conveys considerably more useful information than the first edition but at a cost of greater reading time. This cannot help but disappoint clinical instructors who were accustomed to assign to students the first edition as a few evenings' reading matter as a prelude to clinical cardiological teaching. The scope of the book has been increased by mounting numbers of hemodynamic investigations, extension of knowledge of and greater need for precise diagnosis of congenital heart lesions, and the advance of surgical therapy. Of particular consequence in the new edition is the more adequate clinical interpretation of splitting of the second sound, expanded interpretation of auscultatory findings in mitral stenosis which gives specific hemodynamic information heretofore available only after cardiac catheterization, and the better interpretation of loud musical murmurs that are difficult to correlate with any disease state but which are vexatious for the examiner by their magnitude.

All the lesions subject to surgical management are better described and understood than was possible a decade ago. Congenital and acquired heart disease appears in a new and more optimistic perspective so that clinical distinctions of only academic interest a decade ago have become matters of practical therapeutic concern today. The book is well worth the increased time expenditure necessary to digest it by student or seasoned clinician.

The book is primarily a practical manual, devoid of bibliographic references, and with bare mention of the rich historical heritage of auscultation as an art. To have included such material would have delighted the academician but additional bulk would discourage the clinician who can ill afford to omit reading this important text. W.H.W.

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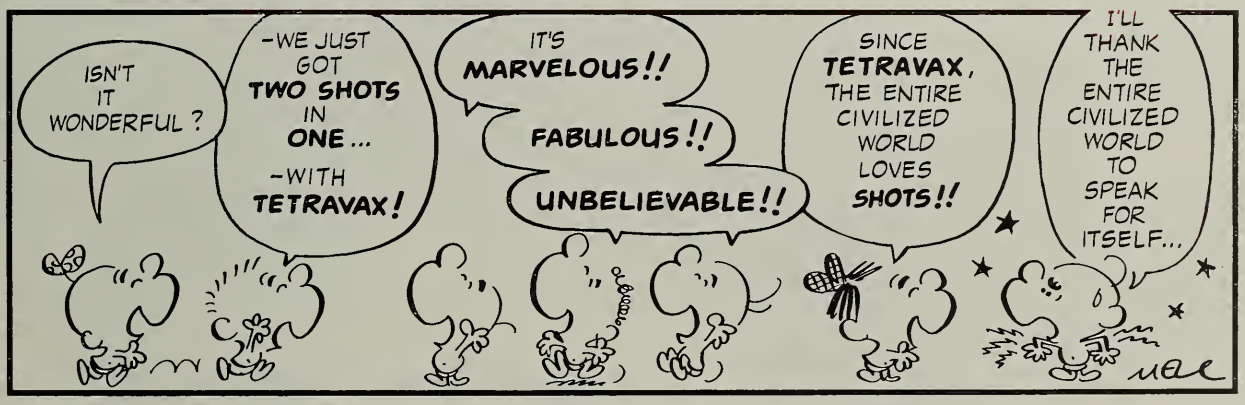
SURGERY OF THE FOOT. Henri L. DuVries, M.D.

(*Continued on page 76*)

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BOOK REVIEWS (Continued)

$12.50. Pp. 494. St. Louis, C. V. Mosby, 1959.

This volume considers the diseases of the foot frequently encountered by the general physician. Surgical correction of these defects is the primary consideration in the text. Since many of them involve the forefoot, toes, and the plantar aspect of the foot, the author describes the surgical correction of these diseases in detail. His own experience is well outlined but procedures originated by others are adequately discussed.

Conservative measures in the treatment of foot diseases are mentioned only briefly, as the author intended. Several chapters devoted to nonsurgical entities seem to have no place in a surgical textbook. The operative corrections of major foot deformities are mentioned, but are too sketchy to be of value.

The book is a bit brief and lacks the over-all concept of foot surgery necessary in a text for the medical student specializing in orthopedic surgery. But it is of value to the general physician and surgeon. W.A.L.

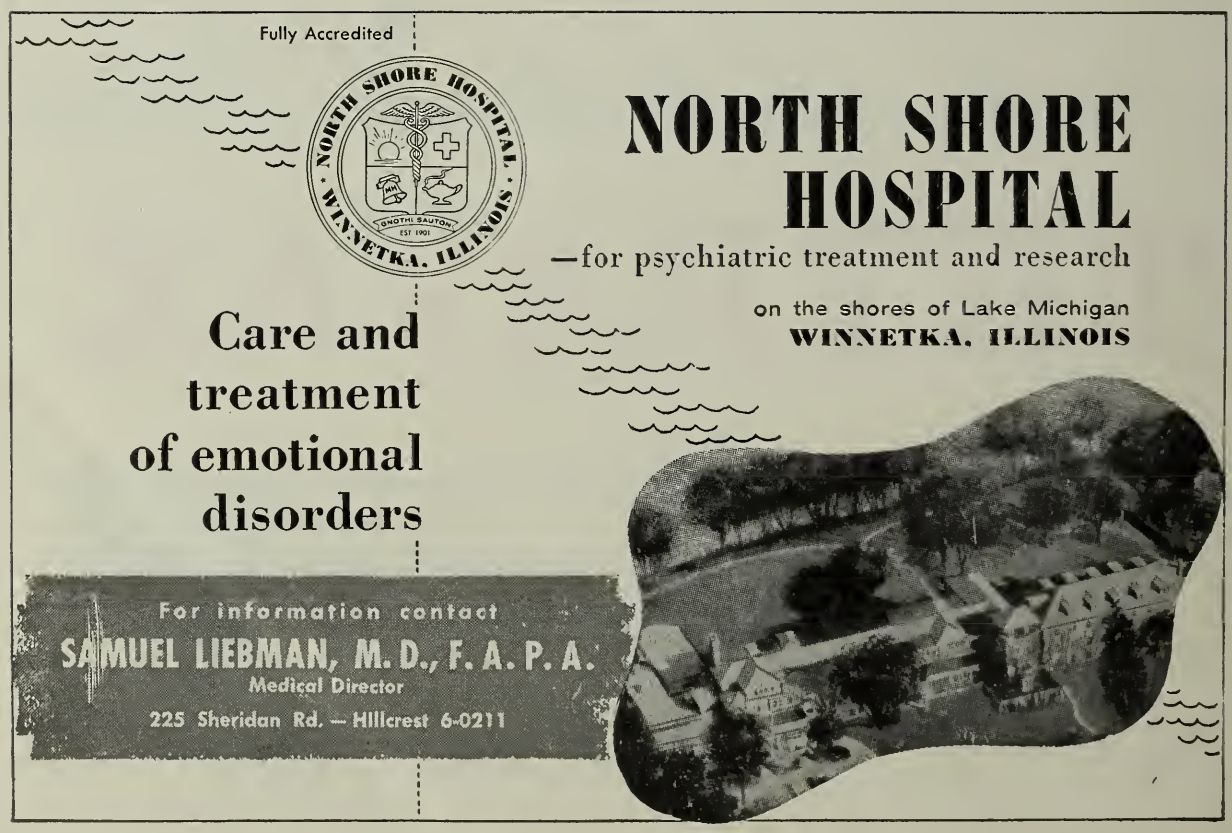
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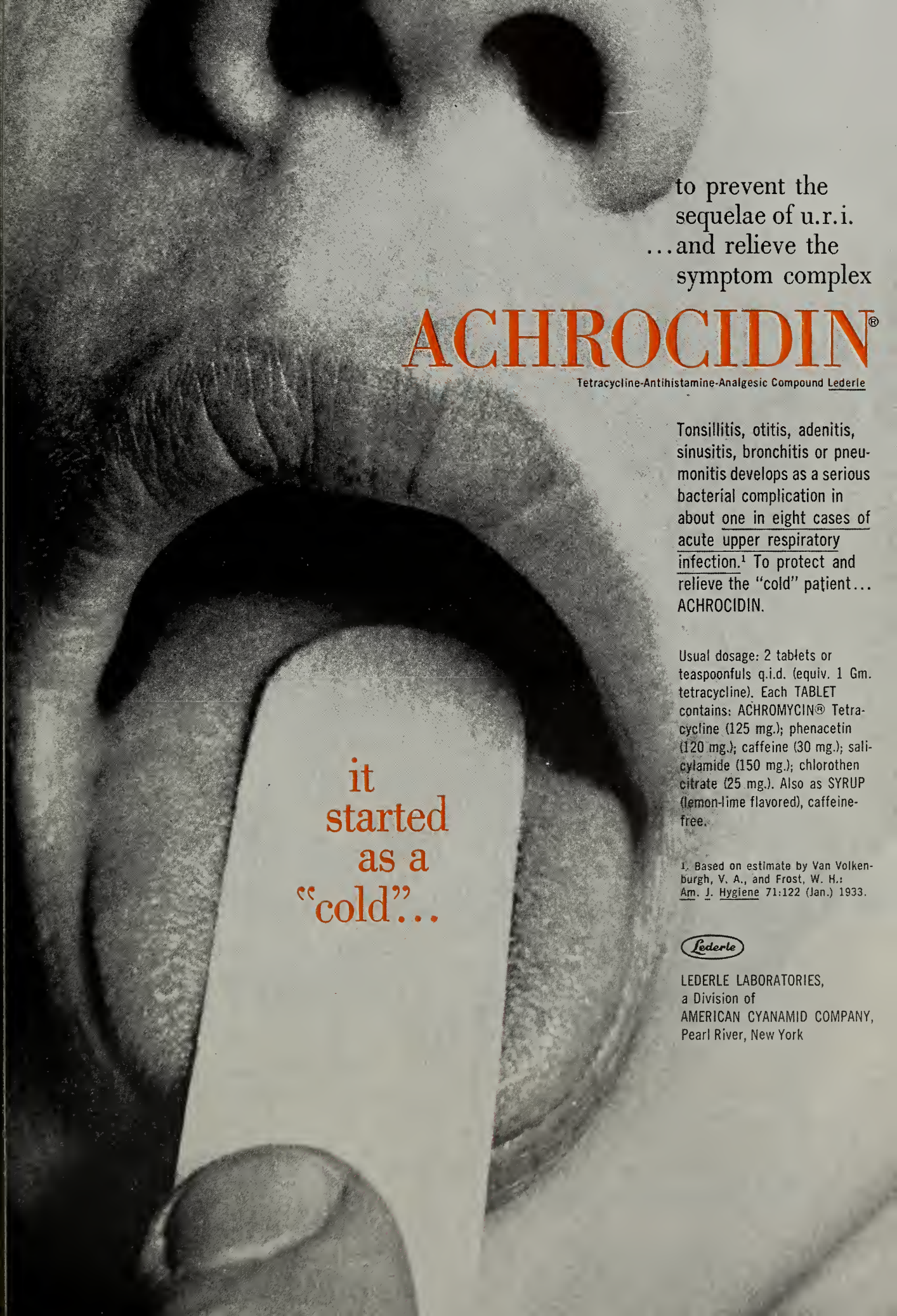
Symposium on Glaucoma. Editor: William B. Clark. Associate Editor: Joe M. Carmichael. Contributors: Bernard Becker, St. Louis; W. Morton Grant, Boston; Joseph S. Haas, Chicago; A. Edward Maumenee, Baltimore; Harold G. Scheie, Philadelphia; Kenneth C. Swan, Portland; Georgiana Dvorak-Theobald, Oak Park; Lorenz E. Zimmerman, Washington. $13.50. Pp. 314. St. Louis, C. V. Mosby, 1959.

During the fifth decade of this century extraordinary progress has occurred in the understanding and the management of all types of glaucoma. Many of these advances have been the clinical application and consolidation of earlier information, combined with a recognition of the mechanism of angle closure glaucoma. In this country, at least, a fairly sharp differentiation has been made between angle closure glaucoma, simple glaucoma, and secondary types of glaucoma.

This volume consists of the Transactions of the 1957 New Orleans Academy of Ophthalmology which met to discuss glaucoma. There are brief discussions of the histology, pathology, and surgical anatomy of the glaucomatous eye; the biochemistry of the aqueous humor; and the

(Continued on page 78)





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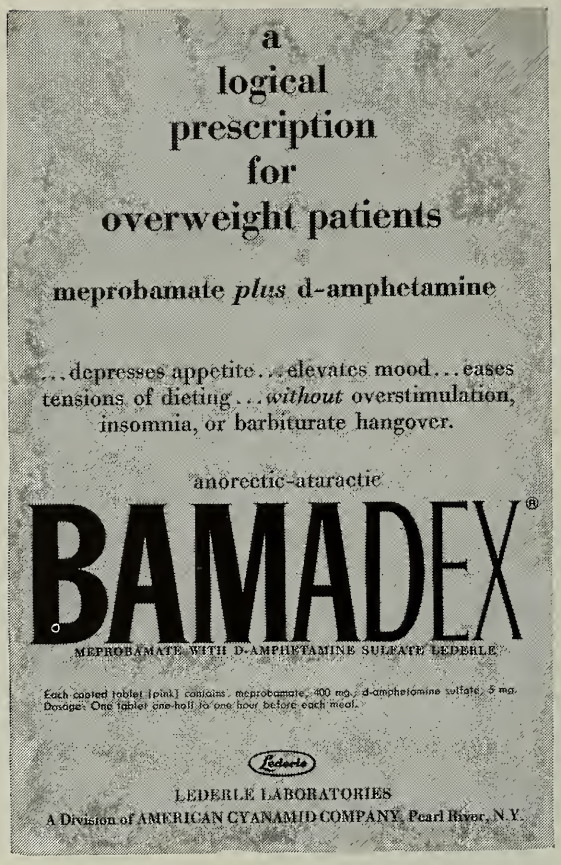
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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

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BOOK REVIEWS (Continued)

diagnosis and classification of glaucoma. Much consideration is given to the medical and surgical management of the disease. A highly informative round table discussion follows. The book is unusually well done from every viewpoint and may be recommended to all ophthalmologists and to their residents. F.W.N.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

STERIC COURSE OF MICROBIOLOGICAL REACTIONS. Ciba Foundation Study Group, No. 2. G. E. W. Wolstenholme, and Cecilia M. O'Connor. Pp. 115. Boston, Little, Brown and Company, 1959.

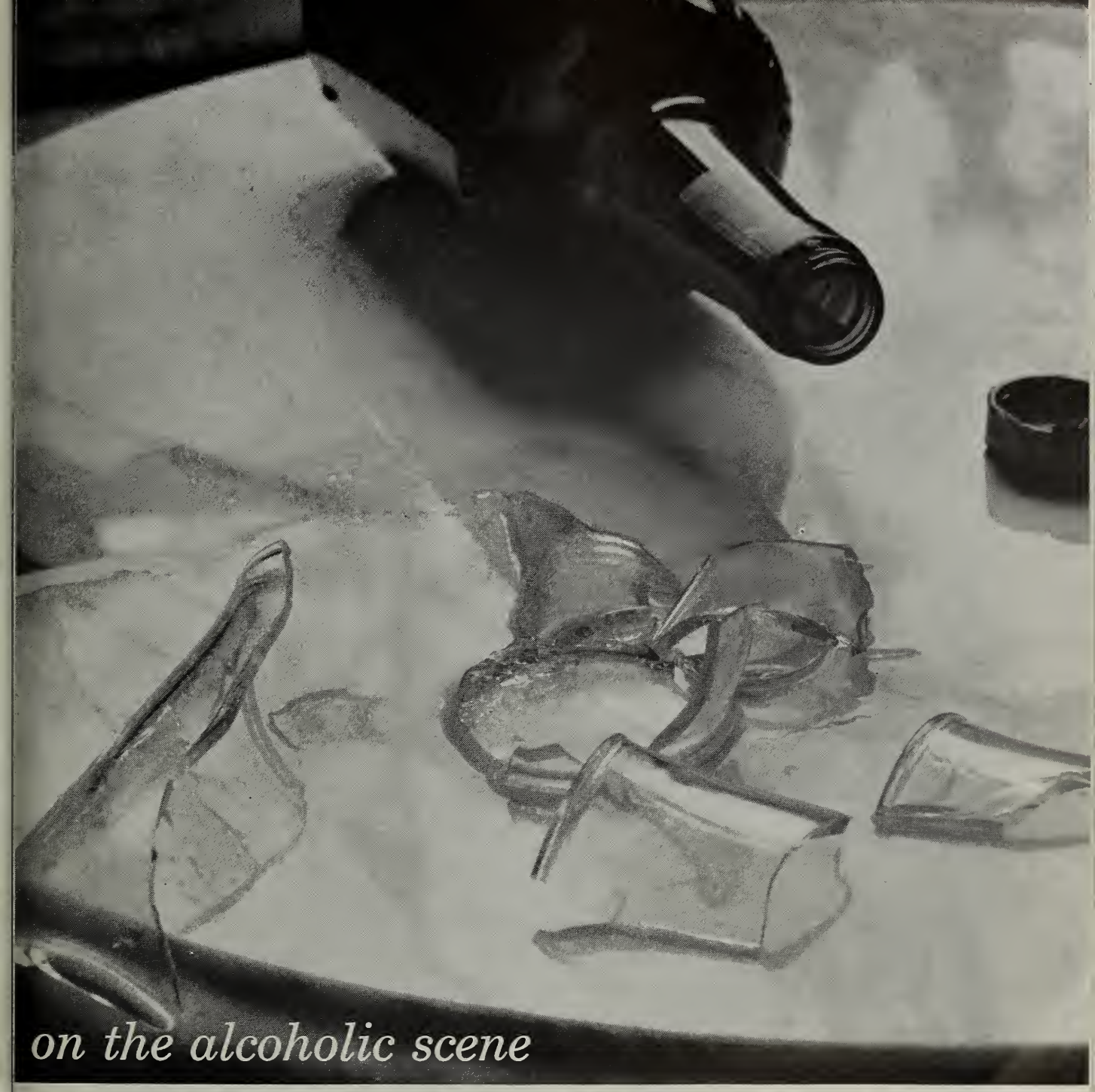
HANDBOOK OF CIRCULATION, Analysis and Compilation by Philip L. Altman. Edited by Dorothy S. Dittmer and Rudolph M. Grebe. Division of Biology and Agriculture, The National Academy of Sciences, The National Research Council. $7.50. Pp. 393. Philadelphia, W. B. Saunders Company, 1959.

DIGEST OF OFFICIAL ACTIONS OF THE AMERICAN MEDICAL ASSOCIATION, 1846-1958. F. J. L. Blasingame, M.D. $5.00. Pp. 779. 1959.

MODERN ASPECTS OF THE GEOLOGY OF NEW YORK CITY AND ENVIRONS. Annals of the New York Academy of Sciences, Volume 80, Art. 4. Pages 1047-1170. $2.50. Published by the Academy, New York.

CURRENT TRENDS IN RESEARCH AND CLINICAL MANAGEMENT OF DIABETES. Annals of the New York Academy of Sciences, Volume 82, Art. 2, Pages 191-644. $4.50. Published by the Academy, New York.

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Miller, R. F.: Clin. Rev. 1:10 (July) 1958

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Medical ethics and economics

Generally speaking, physicians and hospital administrators are not well versed on insurance matters. They are rapidly becoming more so, for reasons which we shall examine in a moment. The attitude all too common a decade ago, "this is a big company and they can well afford to pay" is disappearing gradually. Again, in general, the medical profession is just beginning to learn to separate medical ethics from medical economics. The two are rarely related directly. Professional ethics is another term for virtue, and virtue stands by itself. It cannot be compromised by economic or other mundane influences. Medical economics is receiving much more attention from physicians' organizations than it did 20 years ago. One of the principal roots of the actuaries' dilemma is that patterns of medical practice are changing so rapidly they cannot price medical and hospital services accurately now, much less in the future. *A Review of the Total Problem, by Dr. William P. Shepard, M.D. Talk given at the 68th annual meeting of the Association of Life Insurance Medical Directors of America. October 23. 1959. Hotel Statler Hilton. New York.*

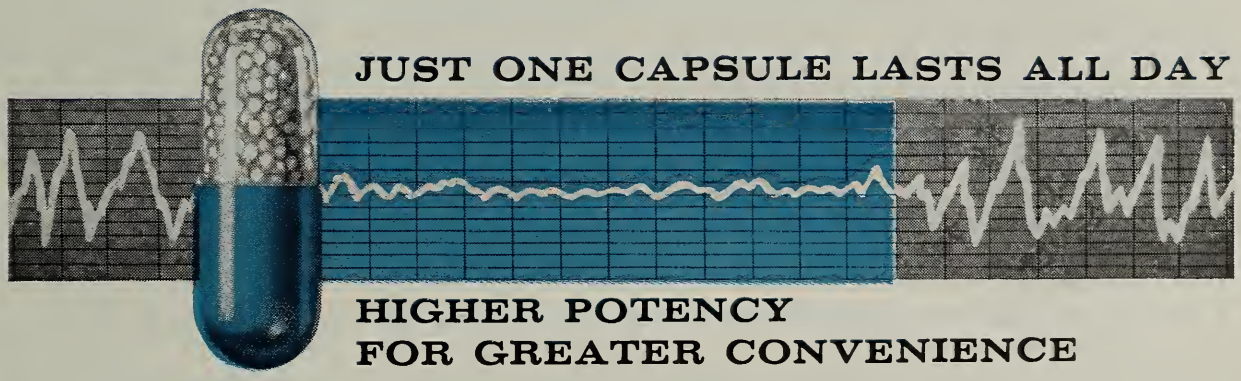


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Executives

The background of the 1,700 (top U. S. executives) is typically middle-western or northeastern. Thirty-eight per cent were born in the midwest, nearly 32 per cent were northeasterners, with New York supplying far and away the greatest number of any state. Their fathers, in the main, were also businessmen: 7 per cent of their fathers were founders of businesses; 17 per cent were corporate executives; and 21 per cent, the biggest single group of all, were the owners of small businesses. Some 18 per cent of the fathers presumably were men of modest means. They belonged to professional groups, such as lawyers, 4 per cent; engineers, 4 per cent; doctors, teachers, and ministers each upwards of 2 per cent.

How well the 1,700 did in college is discernible in the number achieving honors. Less than 2 per cent of all U. S. male college graduates have made Phi Beta Kappa, but almost 10 per cent of the top executives did so; 5 per cent made the dean's list, graduated cum laude, magna cum laude, summa cum laude, or as valedictorians; 11 per cent were members of academic societies. The industries with the most educated executives? Chemicals, insurance, and utilities, the first two running almost side by side in the number of college graduates with chemicals slightly ahead in executives who have taken advanced degrees. As for academic brilliance, the insurance executives are in a class by themselves: 42 per cent of those who were eligible to make Phi Beta Kappa did so, compared to the next ranking industry executives, chemicals (almost 36 per cent) and oil and gas (almost 35 per cent). The lowest percentage of Phi Betas in a major industry — less than 4 per cent — is to be found among the top executives in metals manufacturing. It is interesting to note that eggheads thus have an affinity for the lowest paying industry (the median $50,700 salary of a top executive in insurance is at the bottom of the industry list) and that the highest paying industry (metals manufacturing, with a median of $92,600) is a relatively infertile field for the brilliant graduate bent on getting to the top. *1,700 Top Executives. Fortune Nov. 1959.*

‹ ›

The brave man carves out his fortune, and every man is the son of his own works. — *Cervantes*

wider latitude in adjusting dosage

ARISTOGESIC is particularly effective for relief of chronic – but less severe – pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

Precautions: All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

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Color of eyes and pain

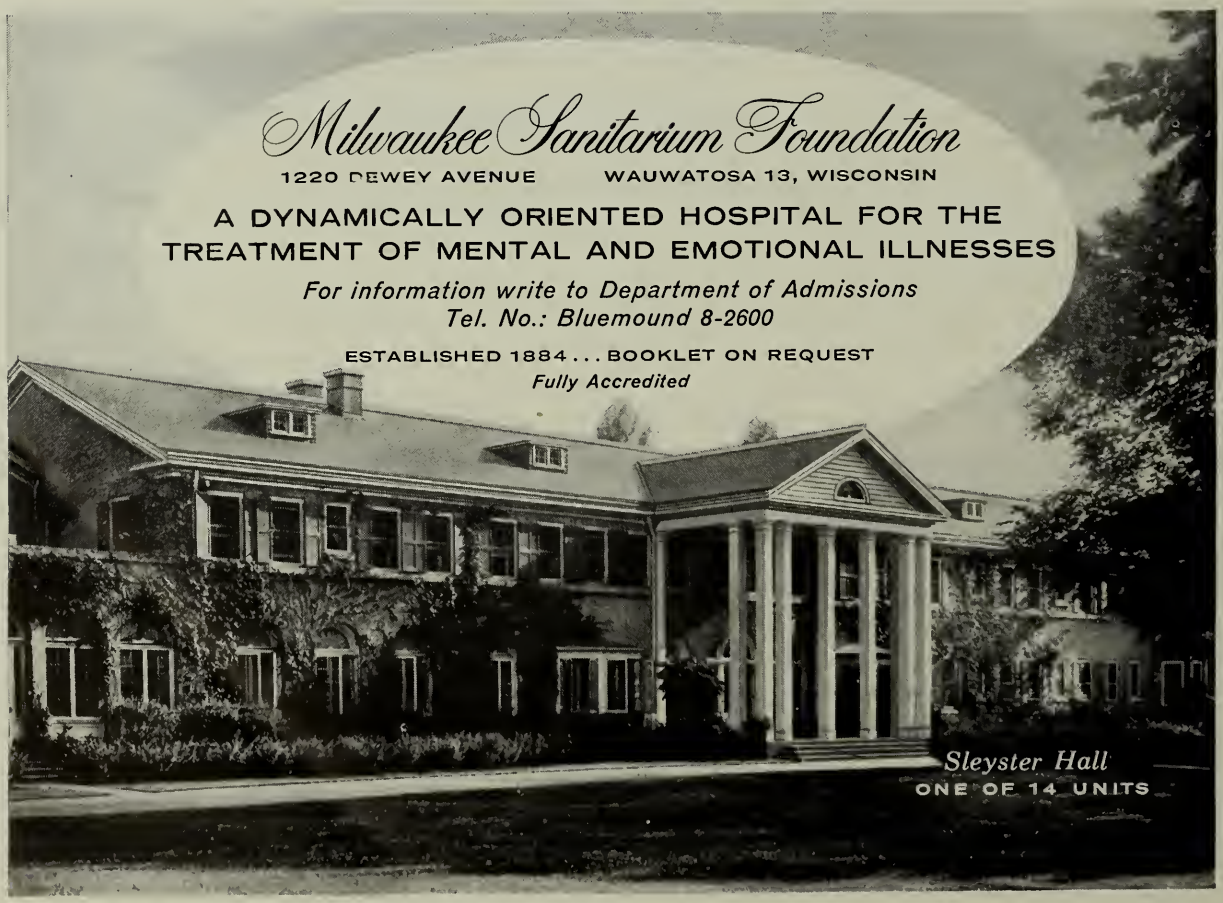
Now a surprising association has been noted — namely, between reaction to pain and color of eye. P. R. N. Sutton, of Melbourne University Dental School, studied 403 consecutive subjects whose teeth were being prepared for filling by a high speed drill. They were Australians of European stock, and their ages ranged from 3 years to more than 50. He classified the reactions to pain in four categories and color of the iris in nine. The judgments were admittedly subjective, but classifying some of the patients again showed that the judgments were reproduced fairly closely. On comparing color of iris and reaction to pain, he found that the bluer the eyes the less the reaction. As the color went through blue-grey, green, hazel, light brown, and dark brown so the reaction to pain increased on the average.

The author does not offer an explanation of these results, but it is possible there is more to them than a freak coincidence. For instance, though the response to pain no doubt owes much to an individual's biological constitution, it is influenced too by his cultural background. Perhaps the patients with blue eyes were mainly of North European stock, traditionally a phlegmatic race, while those with dark brown eyes may have included many descendants of the supposedly more excitable Mediterranean peoples. It would be interesting to know if medical men pay any attention to color of eyes when assessing, as they have to every day, the intensity of pain about which patients complain. *Steely Eyes and Pain. Brit. M.J. Sept. 12, 1959.*

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Strabismus in children

The following questions frequently are raised and warrant some discussion. Who is qualified to examine and treat children with strabismus? Only the physician who is specifically trained in ophthalmology and ophthalmic surgery should do so. Treatment by nonmedical personnel is not warranted or advisable. *John A. Dyer, M.D. The Child with Strabismus. Minnesota Med. May 1959.*



reaches all nasal and paranasal membranes *systemically*[1]



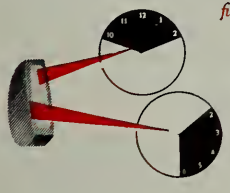
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1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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Foreign bodies in the appendix

Perforation of the appendix by an ingested nail is uncommon. Collins reported that foreign bodies were found in the lumen in 40 per cent of 50,000 appendiceal specimens examined. Thirty-nine per cent of the foreign bodies were fecoliths, 0.1 per cent were common metal pins, 0.05 per cent needles, and 0.08 per cent nails. Of 45,335 surgically removed specimens, 10.8 per cent were described as being either gangrenous or perforated. Sawyer reported a small series of cases of acute appendicitis with perforations due to sharp foreign bodies. It is of historical interest that the first recorded appendectomy was done by Claudius Amyand on December 6, 1735, on an 11 year old boy who had a scrotal hernia with a fistula formation that contained a chronic suppurative perforated appendix. The perforation was caused by a pin in the appendix. *Harry Perelman, M.D. and Harold R. Sherwood, M.D. Acute Appendicitis with Perforation by an Ingested Nail. California Med. Aug 1959.*

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The great man is he who does not lose his child's heart. — *Mencius*

Quackery in nutrition

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Lecithin, falsely represented as a cure for hardening of the arteries, high blood pressure, coronary thrombosis, diabetes, prostate trouble, and other conditions. *Wallace F. Janssen. Quackery and the News. Pub. Health Rep. July 1959.*

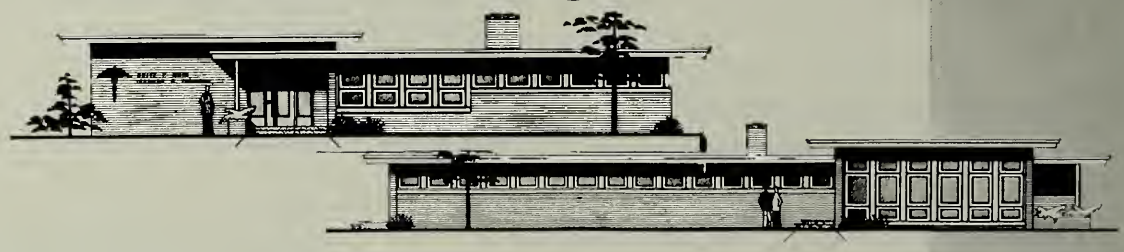
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Give, if thou canst, an alms; if not, afford, instead of that, a sweet and gentle word. —*Herrick*

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—*Samuel Hopkins Adams*

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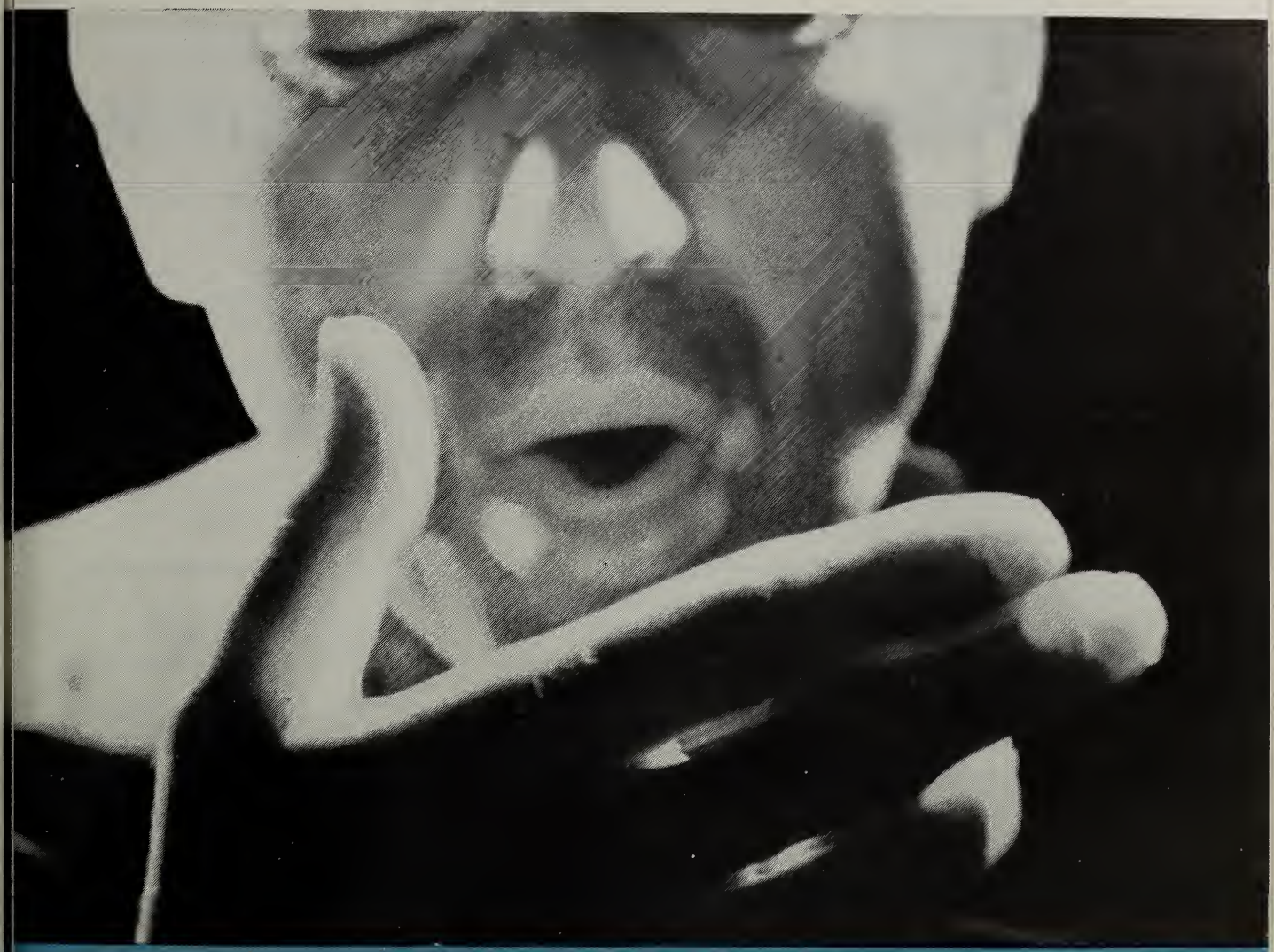
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references: 1. Blanchard, K., and Ford, R. A., Journal-Lancet, 74:433, 1954. 2. Cass, L. J., and Frederik, W. S., Am. Pract. Dig. Treat., 2:844, 1951. 3. Hayes, E. W., and Jacobs, L. S., Dis. Chest, 30:441, 1956. 4. Blanchard, K., and Ford, R. A., Clin. Med., 3:961, 1956. 5. Blanchard, K., and Ford, R. A., Rocky Mt. M. J., Vol. 52, No. 3, 1955. 6. Boyd, E. M., et al., Can. M. Assoc. J., 54:216, 1946.

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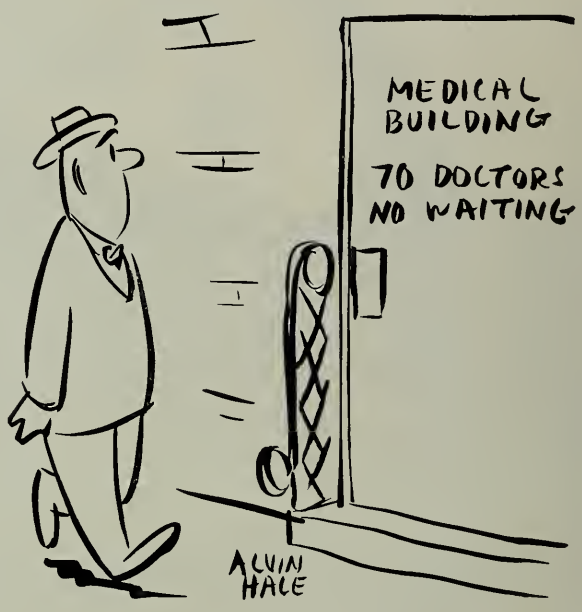
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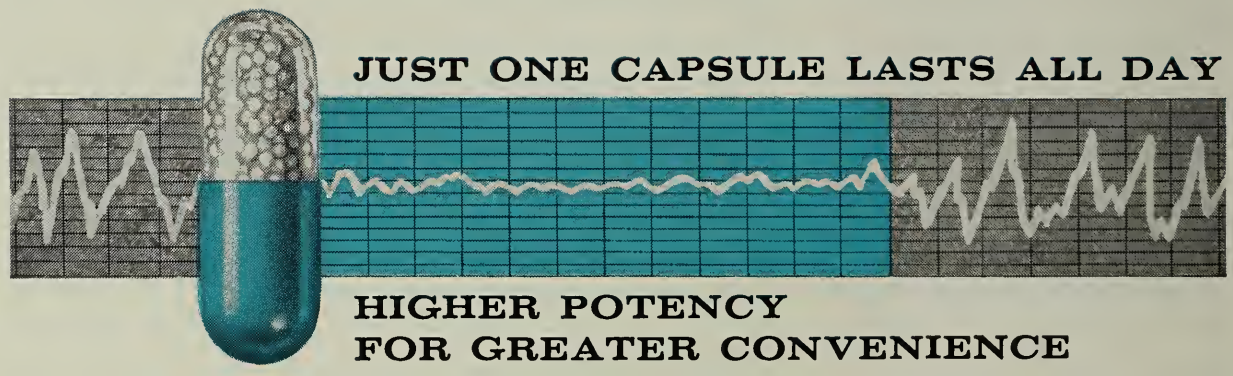
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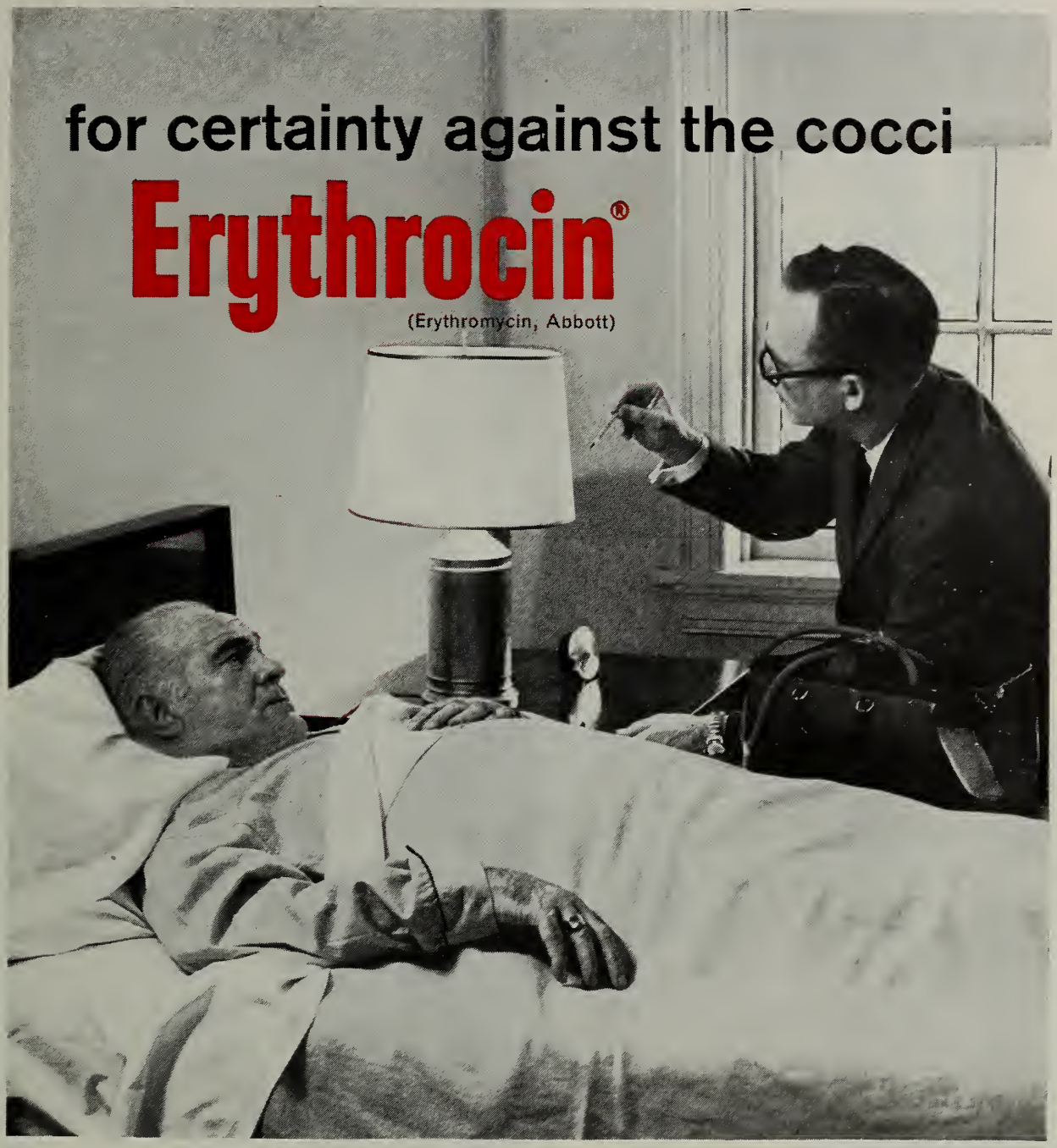
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Regenerating the lens of the eye

Chanturishvili and associates have shown that when small fragments of cytolyzing fetal tissues are introduced into the lens capsule of adult rabbits, from which all easily separable contents have been evacuated, regeneration will take place, giving something like a normal lens in contrast to the incomplete formation of lens fibers that are seen in untreated aphakic eyes. The detailed experimental results reported at Oxford last year are now confirmed in a preliminary study by Stenhouse, Stewart, and 'Espinasse of Hull. So far, experimental studies suggest that the regeneration of lens follows more readily on the evacuation of healthy lens matter from a mammalian eye than on the removal of cataractous lenses. Satisfactory regeneration of lenses in rabbits have, however, been obtained by Sikharulidze after removal of chemically induced cataracts. Studies on these lines are now proceeding at Hull, where cataract is being produced by local irradiation.

In his experiments, Chanturishvili used con-



served minced brain of mice as the necessary neural agent to initiate fiber production in the capsule of the extracted lens of rabbits. What other material can be used for this purpose is still not decided. Despite the considerable theoretical and practical difficulties raised by this work, a substantial advance with clinical possibilities has clearly been made. *Lens Regeneration. Annotations. Lancet Sept. 19, 1959.*

‹ ›

The complexities of diet

A complex dietary interaction of proteins and fats is suggested in tuberculosis by the well controlled laboratory studies of Hedgecock. When lard was the only source of fat in diets of mice, no protein deficiency effect on resistance could be demonstrated. With a special mixture of five fatty acids from coconut oil, however, addition of protein gave statistically significant protection. *John E. Gordon, M.D. and Theodore H. Ingalls, M.D. Interactions of Nutrition and Infection. Am. J. M. Sc. March 1959.*

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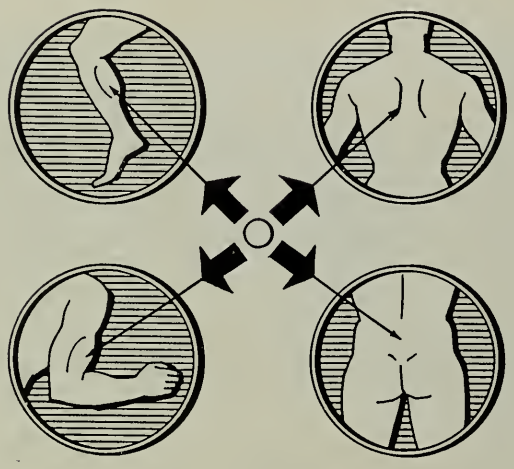
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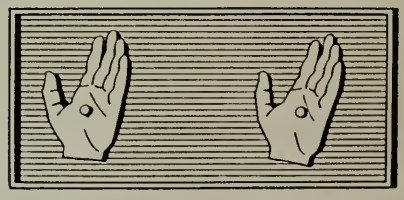
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The unanswerable question

In applying Lord Kelvin's famous dictum to the workaday habits of many economists, one of my revered teachers, Frank H. Knight, used to say: "If you can't measure, measure anyhow." The student of the Soviet economy cannot avoid getting caught on the barb of this remark. Knowing the formidable difficulties of measuring, in a simple and direct way, such a complex and elusive thing as Soviet economic growth, he might refuse the job. But the public will not be denied: the question is too pressing to be left unanswered. The student is thus forced to act on a second principle also often enunciated by Knight, one that he attributes in turn to a revered teacher of his own: No question can be called unanswerable if it has to be answered, and some answers are better than others — or, at least, some are worse. *G. Warren Nutter. Soviet Industrial Growth. Science July 31, 1959.*

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The more sand has escaped from the hourglass of our life, the clearer we should see through it.
Jean Paul

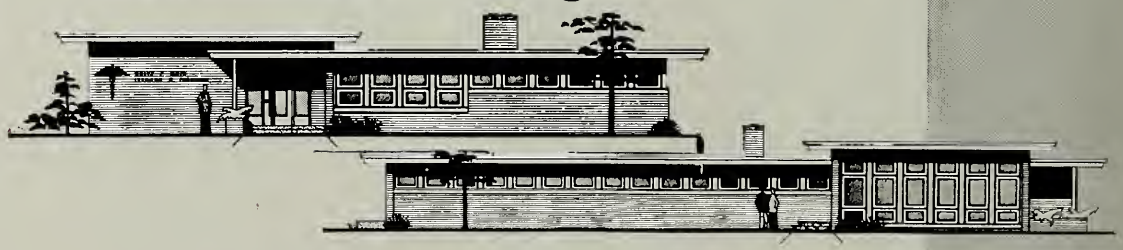
Cholesterol deposits in the lung

The term lipoid pneumonia has been given frequently to the pulmonary inflammation and fibrosis produced by inadvertent aspiration of inorganic or organic fatty materials. However, it has become apparent in recent years that many patients with so-called oil granulomas give no history of aspirating or using any type of oil, and a great number of the granulomas themselves reveal no demonstrable oil deposit on chemical analysis. Many of these granulomas, however, show deposits of cholesterol that are of endogenous origin. From these findings, two separate groups of lipoid granulomas can be said to emerge — both entirely different in etiology and pathogenesis. Their only common characteristic is the presence of substances soluble in fat solvents. *R. H. Sundbert, M.D., Karl E. Kirschner, M.D., and Maurice J. Brown, M.D. Evaluation of Lipoid Pneumonia. Dis. Chest Dec. 1959.*

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From the little spark may burst a mighty flame.
—Dante

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FEBRUARY, 1960
VOL. 117, No. 2

Physiology of the Aging Skin

ALLAN L. LORINCZ, M.D., CHICAGO

The skin changes so conspicuously with the passage of time that its appearance has become an essentially universal standard by which a person's age is estimated. This point is amply supported by the vast effort and fortune expended on cosmetics to mask these changes or even to try wishfully to halt or reverse them.

In considering the factors that bring about the cutaneous appearance of aging, the changes produced in exposed areas by sunlight or weathering should be distinguished from the senile changes that can be observed in areas normally covered by clothing. The changes produced in weatherbeaten areas depend scarcely upon the passage of time but rather on (1) the total amount of radiant energy in the sunburn range of wave-lengths between 2,800 and 3,100 Angstroms which has impinged on the skin, and on (2) genetic factors that determine the skin's susceptibility or resistance to the damaging effects of such radiation. In general the melanin content and thickness of the horny layer of the skin are the chief protectors against solar injury. Fair-skinned persons tend to be primarily deficient not only in these factors but in their ability to respond to solar exposure by augmentation of these defenses.

Genetic predisposition to solar cutaneous injury is strikingly illustrated by xeroderma pigmentosum.[1] In this recessively inherited disorder, even few moderate exposures to sunlight can lead to the development in early childhood of all of the changes characteristic of chronic cutaneous solar injury. The basic physiological or biochemical mechanisms behind the spectacularly heightened susceptibility to solar injury remain unknown.

Chronically weatherbeaten skin is characterized primarily by degenerative changes in the subpapillary connective tissue. Although these changes are more properly termed solar elastosis, they frequently are called senile elastosis. Histologic study of the affected connective tissue by conventional[2] as well as electron microscopy[3] shows it to be interspersed with narrow, elongated, tortuous, relatively basophilic, degenerate, collagen fibers. These fibers have many of the staining characteristics of elastic fibers and in contrast to normal collagen, are susceptible to tryptic digestion.

Skin showing a severe degree of solar elastosis is grossly inelastic and slightly yellowish and develops permanent wrinkles readily. There generally is accompanying telangiectasia of super-

From the Section of Dermatology, University of Chicago.

Presented before the Section on Dermatology, 119th Annual Meeting, Illinois State Medical Society, Chicago, May 21, 1959.

ficial blood vessels, atrophy of the dermal papillae, and flattening of the epidermis with relative thickening of its horny layer. Pigmentary changes in the form of so-called senile freckles and speckled areas of depigmentation also may appear. Finally, premalignant keratoses and various malignant neoplasms tend to develop multicentrically in such degenerated weatherbeaten skin.

As concerns aging of nonexposed skin, our knowledge about the changes that take place is for the most part descriptive. Understanding of the etiologic mechanisms still remains to be developed along with solutions to the larger general biological problems of aging. No answers have been given to the simple questions of to what degree cutaneous aging is intrinsically determined by the genetic and environmental history of the skin itself, or to what degree such aging is secondary to vascular, endocrine, or other senile changes in the individual as a whole. Some preliminary experiments with serial homografting of skin to young hosts in inbred strains of mice have been attempted[4] and degenerative changes are rumored to have occurred in such repeatedly grafted skin. Whether such changes can be interpreted as being simply the result of aging cannot be properly evaluated not only because the cutaneous aging process is poorly defined in mice, but also because it is hard to assess the possible role in producing the observed changes played by trauma incidental to the repeated grafting procedures. Perhaps when the homograft problem becomes solved this question of the degree of cutaneous intrinsicity of aging in man can be answered satisfactorily.

The surface of nonweathered senile human skin is grossly more finely wrinkled, dry, and shiny than that of young skin. Upon pinching such senile skin into a fold it generally feels thinner and lacks the elasticity and turgor of normal skin. This lack of elasticity, coupled frequently with a reduction in subcutaneous fat, results in redundancy and coarse folding. Such increased coarse folding particularly appears about flexures and the facial muscles of expression. Numerous attempts have been made to measure objectively the changes in mechanical properties of aging skin. Schade as early as 1912 devised an elastometer by which he could demonstrate that both the extent and rate of indentation and rebound of the skin following application of a weighted metal knob decreased with advancing age.[5] More recently, Dick studied the mechanical properties of excised pieces of skin and pointed out that normally skin is fitted over the underlying tissues in a somewhat stretched state because of the shrinkage in area that can be observed upon excision of a specimen.[6,7] In elderly persons, this initial tension is diminished markedly, especially in areas where elastic tissue is normally abundant, such as the lateral thighs. A decrease in elastic fibers appears to correlate with this initial laxity of senile skin. However, as the deforming force increases, senile skin offers greater resistance than youthful skin. This resistance to stronger stretching forces is a function of the collagen and it has been suggested that increased intertwining of such fibers, possibly resulting from the decrease in ground substance between them, may account for the reduced extensibility and increased tensile strength of elderly skin.[8]

The superficial atrophic appearance and fine wrinkling of senile skin is apparently more dependent upon the flattening or atrophy of the dermal papillae than upon reduction of epidermal thickness or its reproductive ability. In fact, there is good evidence that epidermal mitotic indices actually may increase with advancing years.[9] A conspicuous feature of the atrophy of dermal papillae in senile skin is loss of the delicate elastic fibers that radiate from the papillae toward the epidermis.[10]

In general, aging seems to modify the epidermis and its various functions, including keratinization and pigment formation, much less than the dermis and the cutaneous appendages. With advancing age, the amorphous ground substance of the dermis decreases while collagen fibers increase, and the mucopolysaccharide-containing, PAS-positive so-called basement membranes between epithelial and endothelial structures and their connective tissue stromata, become more conspicuous.[11] It has even been suggested that the prominent subepidermal membrane in senile skin deserves the name, senile stria.[12]

Although the cornified surface of very senile skin tends to be excessively dry and particularly susceptible to superficial fissuring or chapping, there is some evidence that the total water content of such skin may actually be increased.[13] It is mainly the horny layer that becomes dehydrated and brittle in large measure as a result of diminished water-holding capacity secondary—

at least, in part—to reduced sebum and sweat formation.

Widespread involution of sebaceous glands, with consequent deficient sebum production, occurs postmenopausally in women and considerably later, in about the 70's, in men. Apparently loss of gonadal endocrine factors that stimulate sebaceous glands—namely, progesterone in women and androgens in men—account largely for this sebaceous involution.[14] A curious paradox is the occasional occurrence of striking, isolated hyperplasia of a few facial sebaceous glands in senile skin, giant comedos, and even rather pronounced facial seborrhea. These paradoxical effects may be explained either on the basis of local drops in sebaceous glandular thresholds to endorine stimulation, or on the basis of release of normal inhibition on output of pituitary sebotropic factor either by degenerative midbrain changes or by means analogous to the manner in which increased output of gonadotropins occurs during senescence.[15]

Sweat secretion diminishes gradually with senescence and this reduction becomes particularly pronounced in both sexes after the age of 70.[12] Apocrine secretion falls off earlier and more sharply than eccrine secretion. Senile sweat glands, when stimulated by pharmacological or physiological means, become active more slowly and are more easily exhausted upon such stimulation. The sodium content of senile sweat, particularly in men, may be very low or absent.

There is a general tendency toward diminution of body and scalp hair with aging although paradoxically a few coarse, wild hairs may develop sparsely on the scalp and elsewhere about the head. Axillary hair is commonly lost in old age and such loss commences earlier and is more pronounced in women, no doubt as a result of the rather sudden cessation of gonadal activity which occurs in them. Pubic hair also diminishes in old age, though often less conspicuously than does axillary hair. In addition, physical studies have shown that the thickness, lengthening capacity, and resistance to breaking traction of senile hair all diminish, whereas resistance to breakage by torsion increases.[12]

With senescence, nail growth rates strikingly diminish to about equal levels in both sexes. This is in contrast to the normally more rapid nail growth in young men as compared with that in young women.

The graying of hair is popularly associated with senescence. The time of its onset, however, is much dependent on genetic factors. In very old persons, melanogenesis in pigmented nevi also may cease. There is some evidence to suggest that the physiological reduction of melanogenesis as it occurs in ordinary graying is based on an actual disappearance or loss of melanocytes from the germinative epithelium of the affected hair follicles.[16]

Small blood vessel fragility in senile skin tends to be increased and is based primarily upon degenerative changes in the supporting connective tissue surrounding such vessels. Senile purpura is a particularly striking manifestation of this phenomenon and occurs especially on the dorsal distal halves of the upper extremities in association with severe solar elastosis.[17]

Vasomotor responses to temperature changes in aged skin are sluggish. Frostbite in particular might thus occur more readily in such skin.

Senile skin further shows an enhanced diffusability of substances injected into its dermis as well as a greater susceptibility to the enhancement of the spreading that can be brought about by hyaluronidase.[12] The implications of these observations are obvious, in regard to the spread of infections such as erysipelas.

In extreme old age, the reactivity of the skin to inflammatory stimulti—such as applications of adhesive tape or formalin, injections of bacterial toxins, and ultraviolet irradiation generally is more readily elicited even though the intensities and durations of the reactions may be diminished.[12]

In summary, senile skin can be viewed physiologically as having generally reduced homeostatic faculties and greater vulnerability to injury.

Finally, I would like to consider briefly the effects of applications of sex hormones to senile skin. For practical purposes, such applications of currently marketed estrogen and progesterone preparations have entirely negligible rejuvenating effects on such skin. At best, a trifling increase in hydration of the very superficial atrophic papillae of the senile dermis can be achieved if the amounts of sex hormones applied are restricted to the point where systemic effects are not produced. As conspicuous senile changes in the facial skin, especially loss of elasticity and associated coarse permanent wrinkling, are in-

evitable, even though protection from weathering may prevent their premature appearance, the wise policy is to accept fate rather than smear on essentially useless and expensive hormone creams. Try to keep the pattern of facial wrinkling in a pleasant or character-rich distribution by keeping the facial expression predominantly that way.

REFERENCES

1. Sutton, R. L. Jr.: Diseases of the Skin. 11th ed. St. Louis, The C. V. Mosby Co., 1956. Pp. 1255-57.
2. Percival, G. H.; Hannay, F. W.; and Duthie, D. A.: Fibrous Changes in the Dermis, with Special Reference to Senile Elastosis, Brit. J. Dermat. 61:269, 1949.
3. Tunbridge, R. E.; Tattersall, R. N.; Hall, D. A.; Astbury, W. T.; and Reed, R.: The Fibrous Structure of Normal and Abnormal Human Skin, Clin. Sci. 11:315, 1952.
4. Medawar, P. B.: The Uniqueness of the Individual. London, Methuen, 1957. Pp. 41-42.
5. Schade, H.: Untersuchungen zur Organfunktion des Bindgewebes. 1. Die Elastizitatsfunktion des Bindgewebes und die initiale Messung ihrer Storungun, Ztschr. f. exper. Path. u. Therap. 11:369, 1912.
6. Dick, J. C.: Observations on the Elastic Tissue of the Skin, with a Note on the Reticular Layer at the Junction of the Dermis and Epidermis, J. Anat. 81:201, 1947.
7. Dick, J. C.: The Tension and Resistance to Stretching of Human Skin and Other Membranes, with Results from a Series of Normal and Edematous Cases, J. Physiol. 112:102, 1951.
8. Rollhauser, H.: Die Zugfestigkeit der menschlichen Haut, Gegenbaurs Morphol. Jahrb. 90:249, 1950.
9. Nelson, C. T. (panel moderator): Panel Discussion on the Clinical Management of Skin Disease in Geriatric Patients, J. Am. Geriatrics Soc. 6:575, 1958.
10. Wells, G. C.: Senile Changes of the Skin in Man, J. Am. Geriatries Soc. 2:535, 1954.
11. Gersch, I., and Catchpole, H. R.: The Organization of Ground Substance and Basement Membrane and Its Significance in Tissue Injury, Disease and Growth, Am. J. Anat. 85:457, 1949.
12. Manganotti, G. and collaborators: Contributo Allo Studio Dei Fenomeni Di Senescenza Della Cute Umana. (Relazione tenuta al V. Congresso della Societa Italiana di Gerontologia e Geriatria, Torino, 27, 28, 29 Giugno 1955) Bologna, Tito Mattioli - Fidenza, 1955.
13. Urbach, E: Beitrage zu einer physiologischen und pathologischen Chemie der Haut. II. Der Wasser-, Kochsalz-, Reststickstoff-, und Fattgehalt der Haut in der Norm und unter pathologischen Verhaltnissen, Arch. Dermat. u. Syph., 156:73-101, 1928.
14. Rothman, S.: Physiology and Biochemistry of the Skin. Chicago, University of Chicago Press, 1954, pp. 297-302.
15. Lasher, N.; Lorincz, A. L.; and Rothman, S.: Hormonal Effects in the White Rat. III. Evidence for the Presence of a Pituitary Sebaceous Gland Tropic Factor, J. Invest. Derm. 24:499, 1955.
16. Fitzpatrick, T. B.; Brunet, P.; and Kukita, A.: Nature of Hair Pigment. In: Montagna, W. and Ellis, R. A. (Eds.): Biology of Hair Growth. New York, Academic Press, 1958. P. 255.
17. Tattersall, R. N., and Seville, R.: Senile Purpura, Quart. J. Med. 19:151, 1950.

« « « » » »

The basic research professor

A third type of M.D. is the basic research scientist. His business is scientific discoveries — not treating private patients. One of his principal rewards lies in being first to announce a new discovery. You may say that he plays an adult game of treasure hunting. Furthermore, his success in obtaining the continuing flow of grants by which his laboratory is financed depends on his public relations with the committee members of the granting agencies whose success in raising (publicly donated) funds also depends on publicity in large degree. Careful scientists do not stick their necks out by announcing discoveries of which they are not reasonably certain, only to gain publicity. On the other hand, we know also there is no final, perfect truth in science. There is only approximate or relative truth. The scientist who insists on some impossible standard of scientific perfection before publishing his results probably will never be first to announce anything. Especially will this be so if he adopts the policy that he will publish nothing until his idea has been developed to the point where it is medically useful. Perhaps Mendel followed some such rule. In any case the fact that his work received no real publicity when first announced allowed it to be overlooked for 50 years by the main body of science. *Joseph W. Still, M.D. Medical News and Public Relations. Pennsylvania M.J. Nov. 1959.*

Common Skin Diseases of the Aged

W. N. Slinger, M.D., Rockford

The saddest thing about old age is that its future is behind it. — Santiago Ramon y Cajal.

This comment is a literary gem, but Ramon y Cajal, a Spanish histologist, did not win the Nobel Prize in literature. He won it for medicine, in 1906.

I like to believe that in this remark, he was referring to the characteristic degeneration wrought by the inevitable process of aging. As a dermatologist, I translate this degeneration to the skin, which falls prey to aging as readily as — or more readily than — the other organ systems. These now unpreventable changes are seen in the skin as thinning, shininess, fine wrinkles, scaliness, pigmentary mottling, loss of hair, redundancy, and a variety of small tumors.

Women, for obvious reasons, recognize the approach of senescence earlier than men. The first facial wrinkles, the first gray hairs, fading of complexion, and change of bodily contours are noticed apprehensively. The average woman may not care, but there seems to be some truth in the adage that wrinkles, if due to age, are fine; if due to habit, they are coarse. One reason is that coarse wrinkles may result over the muscles of expression as a genetic characteristic or deep furrows may develop in relation to loss of subcutaneous fat or degree of hydration. Fine wrinkles usually are produced by actual atrophy of the dermal papillae and thinning or flattening of the epidermis. Fine wrinkles increase steadily with age.

In the clinical evaluation of the aged skin, it is important to determine what changes have resulted from chronic exposure to sunlight and weather, and what changes have resulted from the aging process. We must examine thoroughly the covered portion of the body, because it is only in unexposed areas that truly senile skin can be diagnosed.

We all recognize the premature aging of the skin of the farmer's face and hands. Wrinkling, atrophy, splotchy pigment distribution, keratoses, and frank carcinomas constitute the usual cutaneous picture. Yet in this same farmer, the covered skin of the body often is completely free from degenerative changes of any sort.

After deciding to what degree the cutaneous degeneration is produced by exposure and what is produced solely by aging, we next consider genetic factors. The skin's texture and depth of color, in an individual or in a racial group, are of great importance in determining the skin's resistance to the damaging influences of environment.

Peoples of Scandinavian, Teutonic, and Anglo-Saxon descent are ill-equipped, skinwise, to withstand degeneration sequellae from chronic actinic exposure. These fair-skinned peoples are deficient in two respects: the horny layer of the epidermis is too thin for adequate protection against sunlight, and the amount of pigment, or melanin [the second screen] in the basal layer is too sparse. However, in certain individuals there is a rapid response to sunburn by a compensatory hyperkeratosis and hyperpigmentation, which protects the skin from further damage.

The enormous size of the cosmetic industry emphasizes, as nothing else can, the general public interest in preserving youthful skin. Unfortunately, neither cosmetic products nor the medical specialty of dermatology can rejuvenate the skin changes that occur with advancing age. In recent years, there has been a flurry of claims for the use of hormone creams. With the exception of some evidence of local tissue hydration after application of the estrogen-containing creams, there seems to be no effect, beneficial or otherwise. Most of us oppose the use of such

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creams, and will continue to oppose their use, until we know that the percutaneous absorption is negligible even with excessive use. There probably is little danger of estrogen toxicity from average or recommended use; but who knows the zealousness of application that might be attained by a woman determined to achieve a rapid return to youth?

The primary concern of the clinician is not the rejuvenation of aged skin, but proper diagnosis of the presenting symptoms and alleviation of distress.

The aged or senile skin is subject to all the skin diseases that affect young adults. Recognition and treatment of these conditions is much the same regardless of the degree of senility. Nevertheless, a few conditions occur so commonly in the aging skin, special attention and discussion are warranted.

Pruritus

Of all the infirmities inherent in the aged, itching is certainly the most annoying. It also is the most common. A few years ago, Zakon and co-workers made a survey of skin complaints and diseases at a home for the aged. They reported that 42 per cent of the residents complained of itching.[1]

A patient frequently observed is the elderly man who complains of generalized pruritus without apparent skin lesions. His skin is dry but not necessarily in the extreme. It shows the usual thinning and atrophy of age and some scattered excoriations. Because the clinical picture is a common one, it is too often lightly dismissed as senile pruritus. Actually, it is doubtful whether senility of the skin, per se, ever results in pruritus. Most frequently the itching follows (1) external irritations or (2) internal disease.

External irritation results from an acquired dryness usually associated with winter weather as low temperatures allow a poor skin spreading of sebum; from too frequent bathing; and from contact with itch-provoking garments such as wools.

Internal diseases that may induce skin itching without primary lesion are numerous. Arteriosclerosis probably is the most common. It is well to examine the patient with particular reference to diseases of the blood, lymph nodes, liver, and kidneys. Generalized pruritus may be the first symptom of hepatitis, leukemia, diabetes, nephritis, tuberculosis, carcinoma, or lymphoblastoma. To add to the confusion, early mental degeneration or disease often seems to be accompanied by itching of this type.

Generally, pruritus which occurs during the winter months and is associated with dryness and woolen clothing, responds well to conservative treatment. This includes less frequent bathing, avoiding temperature changes and woolen clothing, and the use of bland local creams. If, after a two week period, pruritus is not improved by these methods, then a search for an underlying disease must be made. This can be done only through a series of laboratory examinations.

Senile Purpura

This condition is more dependent upon old age than upon exposure. It was first described over 100 years ago. It is common but seems to receive little attention in our literature.

According to Tattersall and Seville, the condition is not found in anyone under the age of 60.[2] Yet I believe I've seen it occasionally in persons in their 40's. The incidence rises from two per cent in the seventh decade of life to 25 per cent in the tenth decade. The lesions may be petechial or ecchymotic; of wide or limited distribution; and spontaneous or induced by friction, pressure, or other trauma.

Most commonly the hemorrhages occur on the extremities, but they may develop in other areas, even the conjunctival surface. Mucous membrane lesions are rare. The purpuric color fades gradually to leave diffusely mottled areas of yellowish brown pigmentation. The skin is almost always extremely thin, brittle, and transparent.

Senile purpura is difficult to explain. There is no increased incidence of cardiovascular or hypertensive disease. No abnormality in vitamin C metabolism or excretion can be demonstrated when checked by saturation tests. Furthermore, the purpuric condition does not improve through the administration of vitamin C. Bleeding and clotting times and capillary resistance tests are normal. I have never seen an associated blood disorder in any patient with senile purpura. The importance of this disease lies in the extreme fragility of the skin rather than the purpura per se. I've seen a laceration produced by the pressure of the blunt undersurface of a bandage scissors. The resulting abrasion or fracture of the skin from such minor trauma is slow to heal and

often persists as a recalcitrant ulcer, particularly on the legs.

Stasis Dermatitis

Acute and chronic eczematous dermatitis of the leg is a common disease of the elderly. Most often it is associated with edema-producing conditions, especially varicose veins and chronic episodic phlebitis. The dermatitis may exist in varying degrees of severity for years with or without development of an ulcer. Contrarily, leg ulcers may occur with the presence of edema and continue for years without eczematization of the surrounding skin. Nevertheless, is most patients these two go hand in hand.

Frequently one sees an auto-eczematization phenomenon, with an eczematous eruption developing on the patient's skin elsewhere than on the legs. This secondary eruption usually is morbilliform or lichenoid, and quite pruritic. It may occur on the trunk, arms, or even the neck and face. Occasionally the disorder is generalized, regardless of form. It may occur suddenly—almost explosively—accompanied by severe itching, chills, fever, malaise, lymphademopathy, and, occasionally, splenic enlargement.

Eczemas

Many practicing dermatologists are of the opinion that allergic eczematous dermatitis of the contact type is less common in the old person and the infant than in persons of other ages. Assuming this to be true, which I do, we still must acknowledge other types of eczemas that seem more common in the old than in the young. Examples are the eczematous dermatitis surrounding a leg ulcer, which we have just talked about, and the infectious eczematous dermatitis that develops in or about areas of acute or chronic suppurative lesions, such as ulcers and draining lesions.

Because of the auto-sensitization phenomenon, eczematous eruptions of this type tend to be particularly sensitive to medication administered either topically or internally. Overtreatment dermatitis is easily produced by ill advised ointments and home remedies.

Genital Lesions

There has been much controversy in recent years over the terminology applied to genital lesions. Most of the dissatisfaction has been with the term, kraurosis vulvae, which has been and remains confusing because it is a catch-all. In short, it is used too frequently to describe a number of quite different conditions.

Darier defined kraurosis, as translated by Montgomery, as follows: "Kraurosis should be restricted to a sclerosing, progressive atrophy of the mucocutaneous teguments of the vulva, leading gradually to stenosis of the vaginal orifice, disappearance of the labia minora, frenulum, and clitoris, and flattening of the labia majora."[3] If the term kraurosis is reserved for this condition, few objections will be heard. However, this condition, as described, must be extremely rare, for I have never seen it nor have many of my colleagues—men with far more extensive experience than mine.

Nevertheless, four common conditions of the vulval tissues should be considered. First, there is simple senile atrophy of the skin and mucous membranes; the skin is very thin and dry and occasionally vitiliginous. Second, there is localized neurodermatitis, or chronic lichenoid dermatitis as some prefer to call it. This condition is not confined to the elderly, but occurs at all ages. It may follow an acute cutaneous eruption of the vulval or perineal tissue, such as moniliasis or contact dermatitis; or it may develop as pruritic lichenified plaques, perhaps of psychosomatic cause. Occasionally, areas of localized neurodermatitis can be found superimposed on a cutaneous base of senile atrophy.

The third condition is leucoplakic vulvitis. This is strictly a hypertrophic process, whether it occurs in the oral cavity or on the genital tissues. Of this group of vulval changes, only leucoplakia is precancerous. The incidence of malignant changes has been variously reported from 20 to 50 per cent. Leucoplakia most often appears near the clitoris and the inner surfaces of the labia minora. It occurs as single or multiple plaques, and, less frequently, as a diffuse involvement of the vulva and perineum. The perianal area is seldom involved. From the standpoint of accurate diagnosis, leucoplakia, hypertrophic dermatitis, and senile atrophy may occur at the same time.

The fourth condition is lichen sclerosus et atrophicus, which dermatologists have recognized as an entity for many years. This condition is characterized by whitish, flat-topped papules that

may be elevated to some degree. The surface of the papules is smooth and shining, and usually reveals one to several black dots or comedo-like plugs. Microscopically, the dots are really keratotic plugs in the sweat pore orifices. Often, but not always, there are hemorrhagic vesicles, particularly in the vulval lesions. Atrophy soon follows the papular stage, and a parchment-like wrinkling with loss of pigment becomes the primary characteristic. Subjective symptoms are varied. Some patients experience severe itching, and others none at all. The condition occurs more commonly among women than among men. It develops usually as a genital lesion in young girls from ages 2 to 6.

It is not unusual to see this disease undergo spontaneous involution in children and occasionally even in an elderly patient. The disease can start anywhere on the body. Common sites, other than the genital area, are the upper portions of the trunk, neck, arms, and forearms.

The importance of this group of vulval lesions, in my opinion, lies in the fact that only one of the diseases, leucoplakia, is frankly precancerous. It seems imperative, if needless and therefore useless surgery is to be prevented, that the characteristics of each of these diseases become better known and recognized by physicians other than dermatologists.

REFERENCES

1. Zakon, S. J.; Goldberg, A. L.; and Forman, Irving: Geriatric Dermatoses: A Survey of the Skin of the Aged, Illinois M. J. **101**:37 (Jan.) 1952.
2. Tattersall, R. N., and Seville, R.: Senile Purpura, Quart. J. Med. **19**:151, 1950.
3. Ormsby, O. S., and Montgomery, H.: Diseases of the Skin, ed. 8, Philadelphia, Lea and Frebiger, P. 680.

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Iron needs

Well documented evidence reveals that the average American woman has a dietary iron intake of 12 to 15 mg. per day. Of this amount, some 10 per cent (1.2 to 1.5 mg. per day) can be absorbed and utilized. Daily losses, exclusive of menses, pregnancy, or lactation, amount to 1 mg. or less. Hence, she is easily able to maintain iron balance.

During pregnancy, fetal and maternal demands for iron are increased but so is the mother's ability to absorb this nutrient. Evidence indicates that during the third trimester of pregnancy from 3.6 to 4.5 mg. of iron per day may be absorbed from a dietary intake of 12 to 15 mg. As a result, in the absence of complicating blood loss during pregnancy, delivery, or postpartum, iron deficiency anemia does not develop in a normal pregnant woman. The usually accepted amount of menstrual blood loss is from 35 to 70 ml. per period, which is equivalent to 14 to 28 mg. of iron per menses. To meet this normal loss the woman needs an additional 0.5 to 1.0 mg. of iron per day to maintain a constant level of hemoglobin. *William J. McGanity, M.D. and Richard O. Cannon, M.D. Iron Deficiency in Gynecologic Patients. Am. J. Clin. Nutrition Nov.-Dec. 1959.*

Treatment of the Skin of the Aged

Hilliard M. Shair, M.D., Quincy

"The Great Rule of Dermatological Therapy" of our student days advised us to apply calamine lotion to an acute dermatosis and tar to a chronic one. This rule was considered sufficient armament for the young physician to battle the 500 skin diseases in his textbook. The rule is not a bad one, but it applies poorly in treating the skin of the aged. Both preparations are too astringent for any but short-term use on dry and easily cracked skin.

Even the nondiseased aged skin needs something to relieve dryness, to prevent cracking, to increase suppleness, and perhaps to retard or relieve wrinkling. Think of the profusion of day creams, night creams, hormone creams, and antiwrinkle creams offered the aging female. Though these products are overtouted, sometimes to the point of downright prevarication, they fill a definite need.

The evidence that water is the only plasticizer of keratin does not mean that water will give aged skin the relief it needs. For moisture to be retained by keratin, an application of grease in some form is necessary to retard evaporation. Hundreds of items are available for the manufacture of creams, varying from turtle oil and spermaceti to synthetic hormones and complex wetting agents. It is not necessary to know all of these or even about water in oil emulsions to give advice on skin lubrication.

Plain oils and fats still have their place as emollients of the skin. Old-fashioned goose grease is an excellent skin softener. One of my little boys dumped a whole quart of it over himself and his skin shone for days. Lard and hydrogenated oil shortening will satisfy some patients. Corn oil is satisfactory. We often add 5 per cent Tween 80® to corn oil and use it as a soap substitute.

From the Physicians and Surgeons Clinic, Quincy
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Usually more elegant preparations are prescribed. Eucerin®, which is Aquaphor® homogenized with an equal amount of water, is a good example. It can be used with antipruritic and anti-inflammatory medications.

Hydrocortisone 0.15
Menthol 0.075
Phenol 0.15
Zinc oxide 0.6
Bismuth subnitrate 0.6
Eucerin to make 30.0

Wrinkling

Reported success of treatment of wrinkling of the skin will probably not stand objective analysis. There is evidence that temporary improvement is due to swelling of collagen. This is the claimed effect of estrogenic hormone creams. The slapping and massage techniques used by beauticians probably do the same.

We use a grease called Protegin-X® (Goldschmidt) which seems to do some good subjectively. Toilet lanolin and various lubricating creams also are worth suggesting to the patient. Some dermatologists report that fluorinated hydrocortisone lotion is good for wrinkling around the eyes. For deep furrows, dermal abrasion and plastic surgery can be recommended.

Hair and Scalp

Most common of hair changes in the aged is grayness. Those who wish their hair recolored should have no difficulty in getting any desired shade. In case of allergy to hair dye, desensitization is not practical. If hair dye is a necessity, the patient can be pre-tested to dyes of other classes by patch testing.

Male type alopecia in the female apparently is on the increase. Reports from distant places, such as Paris and New York, show that this is as true elsewhere as it is in downstate Illinois. We have used female sex hormone topically on the scalp for a number of years. Once daily the patient rubs in Premarin® lotion or an anti-

seborrheic scalp lotion to which 8 to 16 mg. of diethylstilbestrol has been added to 8 ounces of lotion.

Resorcinol monoacetate 4.5, salicylic acid 4.5, (mercuric chloride 0.2) †, glycerin 6.0, diluted isopropyl spiritus sufficient quantity to make 240.0
† Omit the $HgCl_2$ for long term use.

We have seen no objective cures. In some cases a few strands measure a cm. or more than they did the previous year. The patient often is satisfied by the effort made.

The itching scalp of the aged, both male and female, often shows the thickening of lichen chronicus simplex. Superficial X-ray therapy is given over a period of four to six weeks, not exceeding a total of 300 r. An antipruritic scalp lotion is prescribed to be used once or more daily.

Menthol 0.3,
Coal tar solution 8.0
Salicylic acid 2.0
Camphor water 45.0
70% isopropyl spiritus q.s. ad 180.0.

In resistant cases, a small amount of 20 per cent podophyllum resin in compound tincture of benzoin is painted on the worst spots once weekly. Internal antipruritic medication often is prescribed as in senile pruritus.

Keratoses and Leucoplakia

(The treatment of benign and malignant neoplasms of the skin of the aged is not included in this paper.)

For small or thin keratoses no anesthetic is needed. After superficial curettement, lesions are painted lightly with liquefied trichloroacetic acid. A wisp of cotton is wrapped tightly over the point of a toothpick and wetted with liquefied trichloroacetic acid. Enough is applied to cause whitening. For thicker keratoses, a local anesthetic solution is infiltrated intradermally beneath the lesion. The lesion is then removed with a curet and painted with liquefied trichloroacetic acid, electrodesiccated, or electrocanterized. Usually cure of the lesion may be achieved without a scar.

Many textbooks and articles list gamma ray therapy from X-ray and radium sources as a method of choice in the treatment of keratoses. With this we cannot agree at all. The gamma ray dosage needed to destroy a keratosis may replace one troublesome or premalignant lesion with another—the radiation scar.

In the hands of those trained in its use, cryotherapy with solid carbon dioxide or liquid nitrogen is satisfactory for keratoses.

The benign lentigo or liver spot on the face, hands, and forearms also can be treated by the use of trichloroacetic acid or cryotherapy. It is not necessary in any of these lesions to achieve cure on the basis of one sitting. There is less chance of scarring if the patient is treated mildly at repeated intervals of a month or two.

Leucoplaskia, both of the lip and intraoral mucosa, is similar to senile keratosis. If thickened, it should be removed under topical and local anesthesia with a curet and light electrocauterization. Tobacco in any form (not forgetting snuff dipping and tobacco chewing) should be prohibited. We have used a vitamin A and D ointment on the lips for years without too definite evidence of its effectiveness. In intraoral and tongue leucoplakia, a buccal tablet of vitamin A of 75,000-unit strength used once daily really helps.

Senile sebaceous adenomata of the face are treated occasionally because of their appearance or biopsied to distinguish from basal cell epitheliomata. Anesthesia with a cube of ice may be sufficient for excision of the lesion with a sharp scalpel. In larger lesions, local anesthesia and light electrodesiccation are preferable.

Senile Pruritus

The itching of the elderly person can be extremely distressing and disabling. In most cases, a fairly simple combination of internal and external therapy gives relief. Baths with starch, oatmeal, or oil are useful. We suggest a quarter of a commercial package of laundry starch, such as Linit or Argo, plus two tablespoonfuls of corn oil in the tub. Since the addition of starch and oil to the bath water increases the possibility of slipping, the patient should be attended in the bath. After the bath, apply an oily application, such as the Nivea® skin oil with 1/8 of 1 per cent menthol and 1 per cent salicylic acid. Anti-itch tablets usually are helpful. The most commonly prescribed medication and sometimes remarkably effective is Temaril® in the form of 2.5 mg. tablets, to be taken one of four daily. Often, however, a 5 grain aspirin tablet is as effective or even more so than Temaril. Benadryl®, Pyribenzamine®, or Atarax®. Male sex hormone is given

intramuscularly. We give Depo® testosterone, 25 mg. once weekly, or 100 mg. once a month. I have been assured that this dosage will not stimulate latent prostatic carcinoma into activity. A mixture of estrogenic hormones and male sex hormone may be preferred. In the wintertime, the patient also is advised to increase the humidity of his home, to avoid wool against his skin, and — if he can afford it — to go to Florida.

Perleche

Cracked, infected, eczematized skin at the corners of the mouth can be quite a problem in the aged. Permanent cure usually depends on increasing the distance between the maxilla and the mandible. This means procuring dental plates for the edentulous; or, it means lining the patient's dental plates sufficiently to overcome the loss of space resulting from shrinkage of his alveolar ridges. Where the history suggests a poor diet, vitamin B capsules or riboflavin 5 mg. are given three times daily. Topically, a small amount of 5 per cent ammoniated mercury in zinc oxide ointment counteracts secondary pyogenic infection and leaves a protective hydrophobic coating against licking and drooling. If there is delay in healing, superficial roentgen ray therapy (half-value layer, about 1 mm. of aluminum) should be given weekly up to four or six doses of 80 r each.

Herpes Zoster

Painful neuralgia, which is a not infrequent sequel to herpes zoster in the aged, cannot definitely be prevented. In the extremely aged this neuralgia can be so devastating that shot-gun attempts at its prophylaxis or treatment are justified. Examples of such measures are X-ray therapy to the involved ganglia, vitamin B_{12}, 1,000 mcg. subcutaneously for seven to 14 days, injections of 2.6 cc. of Protamide® daily for a week or more, or a short course of suppressive therapy with corticosteroids. A thick shake lotion

Equal parts by weight of zinc oxide, talc, glycerin, and water.

or Lassar's paste applied thickly and covered with cotton helps keep pain-provoking stimuli off the skin. If persistent and uncontrollable pain develops, neurosurgical consultation should be obtained.

Foot Problems of the Aged

Corns, callosities, and deformed and thickened toenails are quite disabling and orthopedic consultation is needed in many cases. Regular visits to a chiropodist should be advised unless the physician himself undertakes to become proficient in caring for feet.

Paring of corns and calluses, soaking the feet in warm water, proper padding with foam rubber and mole skin adhesive tape, and soothing foot powders and creams are needed by many of the aged. Thickened and clawlike toenails (onychogryphosis) can be kept manageable by soaking, clipping, and filing.

Neurotrophic perforating ulcers of the foot may be seen, more frequently in the diabetic. The administration of internal antibiotics over a long period of time, cutting away the callus around the ulcer, the use of 1 to 5 per cent silver nitrate solutions and local antibiotic powders and ointments may cure these ulcers. The disease causing the neurotrophic disorder also must be managed.

Leg Ulcers in the Aged

Most leg ulcers in the aged, like those in the middle-aged group, are on the basis of stasis from varicose veins. A few are arteriosclerotic ulcers of the skin.

Treatment results are gratifying in all degrees of stasis dermatitis and ulceration, even those with marked lymphedema and ulceration over a score of years. Though the simplest treatment is complete bed rest until healing, it usually is not advisable. A surgeon should be consulted concerning the advisability of vein surgery.

In the swollen ulcerated leg, the initial treatment aims at the reduction of swelling and the control of infection. This ordinarily takes five to 14 days. The patient is instructed to lie flat, elevating the leg "above the heart." Sitting in a chair with the legs stretched out on another chair is not sufficient elevation. Thick, sopping wet dressings of 1 per cent boric acid solution are applied for 30 to 60 minutes four times daily. After the wet dressing a soothing lotion

(Neomycin 0.5)+
(Hydrocortisone 0.15)
Phenol 0.6
Zinc oxide & talc each 15.0
Glycerin 10.0
Water to make 90.0
(The neomycin and hydrocortisone are for short term use.)

is painted on. Antibiotics are administered if infection is present.

When swelling has receded and the infection seems under control, the leg is wrapped with a 4 inch wide commercially prepared zinc-gelatin bandage (Unna paste bandage). The bandage starts just behind the toes and goes up to the knee. Before bandaging, the ulcer may be powdered with neomycin or painted with gentian violet solution and/or packed with sterile Gelfoam® powder or sponge. The first boot usually is removed in one week. If the area is doing well, the removal and re-application is continued every two or four weeks until healing. Then elastic bandages or elastic stockings are prescribed. Some patients prefer wearing the Unna paste boots indefinitely and are instructed in the method of application.

Proteolytic enzymes are available as topical powders and ointments, and as oral, buccal, and parenteral medication for the treatment of leg ulcers. Our experience is insufficient to report more than an impression. This impression is not yet favorable.

A generalized eczematoid dermatitis, especially of the upper extremities, face, neck, and upper trunk may occur in stasis dermatitis and ulceration. If it is severe, a short course of ACTH or cortisone may be needed in addition to the regular treatment of the leg. A cream lotion

*Hydrocortisone 0.3
Menthol 0.3
Phenol 1.0
Zinc oxide 30.0
Talc 30.0
Glycerin 7.5
(Isopropyl) alcohol 7.5
Hydrophilic ointment 60.0
Water 120.0

containing hydrocortisone and antipruritic agents is used topically. If the hydrophilic ointment USP is not readily available, Multibase® or other proprietary hydrophilic ointment may be substituted. On small patches of eczematoid dermatitis, .1 per cent Aristocort® acetonide ointment or lotion is helpful.

The patient with an arteriosclerotic ulcer often cannot tolerate an Unna boot. We use the boot if it does not increase leg pain. Vasodilating drugs such as Priscoline® and Peritrate® are used internally though we have not seen any benefit from them. Nursing the ulcer to healing is a long process. We try everything including the old German "black salve" of 1 per cent silver nitrate and 3 per cent Peruvian balsam in petrolatum.

Lichen Sclerosus et Atrophicus

The senile vulva may develop leucoplakia, lichen sclerosus et atrophicans, or kraurosis. The male glans penis and prepuce also are affected by these diseases. In our experience, lichen sclerosus et atrophicans in the male or female is much commoner than leucoplakia or kraurosis. The treatment is symptomatic. Reversal to normal skin is not to be expected.

The most effective medication for lichen sclerosus et atrophicans is one of the topical corticosteroid lotions. At different times other soothing lotions, anti-eczematous creams, and protective ointments are needed. We have had no experience with senile vulvitis. For this condition our gynecologists have in the past used antihistaminic or estrogenic hormone ointments. At the moment, a testosterone ointment is being tried.

Miscellaneous Dermatoses

There is a major difference in the treatment of the chronic eczemas and psoriasis in the aged as compared with the management of the same diseases in a younger person. X-ray therapy and arsenical therapy, which we ordinarily use as little as possible, can be used much more freely to relieve the aged. You need not worry about the genetic effects of radiation therapy in a patient 75 years of age. Nor is it likely that 30 years hence someone will give enough additional X-ray therapy to the same area to cause radiodermatitis. Rather, X-ray therapy and arsenical therapy are less likely to cause serious or disastrous results in the older patient than the present day vogue for administering adrenotrophic hormones and corticosteroids. However, no matter what the age of the patient, X-ray treatment should be administered with care and thought and only by someone expert in its use.

Old-fashioned arsenical therapy sometimes is successful in chronic eczemas, psoriasis, the psoriasiform eruptions of the scalp, hands, and feet, dermatitis herpetiformis, and low grade lymphoblastomata. It is not likely that late sequelae of the overuse of arsenic will be seen.

In administering arsenic we prefer the daily subcutaneous injection of 2 per cent sodium arsenate solution, if the patient can arrange to have this done. The solution (in a rubber stoppered bottle) contains 2 per cent sodium arsenate and 1 per cent phenol in 30 cc. of water for

injection. The starting dose is one minim. This is increased daily by a minim until 16 minims (1 cc.) is reached. The 1 cc. subcutaneous dose is continued for a week or two. If it is not effective, it is stopped. However, if the dermatosis is involuting we reduce the dosage and the frequency of injections over a period of a few weeks until the patient is receiving 10 minims once weekly.

The oral method of arsenical therapy is used more frequently. We prescribe one part of potassium arsenite solution (Fowler's solution) and two parts of peppermint water to make two ounces. The prescription is labeled, "No Repeat." The signature gives the dose as 5 to 45 drops three times daily in a little water or milk. Each day the dose is raised one drop (thus 6 drops three times the second day, 7 drops three times the third day, and so forth). Rarely do we go over 30 drops three times daily. Improvement should be well under way in three or four weeks. After improvement has been achieved, the dosage goes down in the same fashion that it went up. A course should terminate within three months of onset. In either form of arsenical therapy, side effects must be carefully watched for. These are gastrointestinal upset, purpura, herpes zoster, exfoliative dermatitis, and neuritis.

Sometimes malignant and widespread skin diseases are only slowly progressive in the aged. Thus, in very slow moving cases of mycosis fungoides, Kaposi's sarcoma, and pemphigus vulgaris, treatment should be adjusted to the symptoms rather than to the diagnosis. Ardent therapy with massive dose X-ray therapy, nitrogen mustard, or triethylmelamine, are best avoided. These measures may improve the disease and simultaneously shorten the life of the patient. Where long-term administration of corticosteroids is needed in the aged, one should insist on optimal supervision of the patient. Otherwise, it may be just as well to let the older person die of his disease as of steroid therapy complications. Of course, in actual progressive and potentially fatal dermatoses, even in the aged, properly supervised corticosteroid treatment should not be withheld.

Syphilis

In our practice the treatment of syphilis in the aged (or even in the young) presents one insuperable difficulty — lack of patients. In late syphilis, whether latent, visceral, or of the central nervous system, penicillin is the basic treatment. Our dosage for late lues varies from 10 to 20 million units given over a three or four week period. The largest doses would be given in CNS infection.

In cases of serious damage to the heart or blood vessels from syphilis or in a recognizable space-filling central nervous system gumma, there is threat of therapeutic paradox. Preparation with bismuth subsalicylate injections and saturated solution of potassium iodide by mouth for a month prior to penicillin therapy may prevent the untoward complications of too rapid a cure. In such a case, as in the nonsymptomatic aged syphilitic, specific treatment may be omitted altogether.

SUMMARY

Most skin therapy in the aged is gratifyingly successful. Emollient creams, sex hormones, antipruritic tablets, X-ray therapy, and arsenical therapy are more commonly used here than in younger groups. Internal corticosteroids are best avoided except in progressive or disastrous discases. Topically applied corticosteroids and oily lotions have wide use. Seborrheic keratoses, senile keratoses, and leucoplakia are treated with acids, freezing, cautery, desiccation, or surgery. Senile pruritus is controlled largely with oils, antipruritic internal medications, and hormones.

Leg ulcers respond to antibiotics and Unna paste boots. Non symptomatic or slow moving conditions in the aged are treated cautiously or not at all.

Indications for Surgery In Middle Ear Deafness

Bruce Proctor, M.D., Detroit, Michigan

Hearing impairment is a handicap common to some 17 million Americans. Of this number, approximately 3 million occur in children. This is a total greater than the number of children afflicted with blindness, cerebral palsy, and epilepsy combined.

Modern developments in otological surgery have contributed significantly to restoration of hearing loss in various types of middle ear deafness. Diseases of the inner ear, however, with defective neural structures, have so far eluded effective medical or surgical treatment.

Middle ear deafness arises as a result of interference with proper transmission of air borne sound waves from the tympanic membrane through the conducting ossicular mechanism of the middle ear to the inner ear fluid system. The third ossicle, the stapes, fitted in the oval window, works much like a piston with its to and fro vibrations setting up the inner ear fluids in motion. Since fluid is incompressible it is essential that the round window membrane should move in an opposite phase to movements of the stapes in the oval window. Vibrations in the inner ear fluids set the basilar membrane of the cochlea into motion at selective levels for the frequency characteristic of the sound wave heard by the ears. At this point the organ of Corti is stimulated and the appropriate neural impulse registers the sound being heard.

A variety of middle ear mechanical disturbances are recognized. Among them are congenital developmental defects of the external auditory canal and middle ear structures, otosclerosis with bony fixation of the stapes, eustachian tube insufficiencies, middle ear suppurations and effusions, adhesions in the middle ear, destruction of the drum or portion of the ossicular chain by disease, tumors in the middle ear, and traumatic or surgical dislocation of the ossicles.

Acute Middle Ear Inflammations

From the standpoint of preventive medicine, the management of acute middle ear inflammation is extremely important. Here the generalist and the pediatrician can do much to prevent subsequent permanent damage to middle ear structures. It cannot be too strongly emphasized that simple myringotomy has been badly neglected and even abandoned by the majority of practitioners. Severe upper respiratory infections are now treated with antibiotics and chemotherapeutic agents. What might well have developed into a suppurative otitis media may now be seen as a middle ear effusion. The patient may complain of only slight to moderate degree of deafness. The drum presents a grayish or yellowish color, depending upon the nature of the fluid, the short process of the malleus is prominent, and most important of all, the handle of the malleus has a narrow chalky-white appearance. Factors contributing to malfunction of the eustachian tube in such cases must be given due consideration.

Of all surgical procedures probably none is performed as carelessly and indifferently as the adenoidectomy. Enlarged and inflamed adenoid tissue should be removed meticulously, preferably under direct vision, until the underlying fascia is cleanly exposed. A poorly executed adenoidectomy is one of the reasons for persistent middle ear inflammation in children. Persistent suppuration in the paranasal sinuses and uncontrolled nasal allergy are other important factors.

If middle ear effusion is noted in a child with impaired hearing and diseased adenoids, a limited myringotomy and microaspiration of the middle ear at the time of adenoidectomy should be done. Frequently the secretion is copious and of a heavy mucoid nature. In the subsequent

Associate Clinical Professor, Wayne State University, Detroit.

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postoperative period, inflation of the eustachian tube usually hastens the resolution.

Occasionally the effusion persists even though repeated myringotomies and aspirations are done. We can then resort to the insertion of a small semi-permanent polyethylene tube into the middle ear by way of an incision in the outer canal wall, adjacent to the drum, with elevation of the intact drum. The tube can be removed ly, if these measures fail, deep X-ray therapy to once the middle ear remains free of fluid. Final- the eustachian tube may restore adequate ventilation of the middle ear.

Otosclerosis

A common cause for deafness in adults is otosclerosis. This is due to the formation of new bone between the footplate of the stapes and the adjacent bony walls of the oval window niche which stops the normal piston action of the stapes in the oval window. Twenty years ago Lempert proposed the fenestration operation to by-pass the defect in the oval window, by creating a new window in the wall of the bony labyrinth. This window was kept from closing by covering it with a pedicled tympanomeatal flap. The success of this procedure is well known. More recently, beginning with the work of Rosen in 1952, surgery has been directed to loosening the stapes from its bony attachments to the walls of the oval window. At first, merely fracturing, the stapes loose by pressure to the head or neck of the stapes was done. This gave better immediate hearing results than did fenestration because the former did not utilize all the mechanical benefits of the ossicular chain. Soon, however, a significant percentage re-ankylosed, with return of hearing loss. Also, with pressure exerted on the head and neck of the stapes, the delicate crura of the stapes often fractured before the footplate was loosened.

Attention was then directed to the footplate itself, using adequate magnification. The site of the otosclerosis was approached with needles and fine chisels and the stapes loosened directly with lessened tendency to crural fractures. Hearing results improved. Further progress has carried this surgery to the point where total circumferential otosclerosis, involving the entire perimeter of the footplate, can be removed and the opening in the vestibule covered with a vein or fascial graft. An artificial stapes made of polyethylene tubing or fine wire is placed between the incus and the graft since this procedure requires removal of the entire stapes. We are now at the point where 75 per cent or more of otosclerotic patients can have satisfactory hearing without the use of hearing aids. Occasionally, when stapes mobilization surgery has failed because of a severe degree of otosclerosis we still can perform a fenestration operation. Among the advantages of stapes mobilization over fenestration are: 1. Much shorter operating time under local anesthesia; 2. Better average good hearing results because of preservation of the ossicular chain; 3. Much less period of hospitalization (usually 24-48 hours); 4. No postoperative mastoidectomy cavity requiring periodic medical attention.

Tympanoplasty

Prolonged inflammation in the middle ear often results in ischemic necrosis and ulceration of the middle ear mucosal lining. If these areas communicate with the stratified squamous epithelium of the external auditory canal, the latter will invade the middle ear and produce cholesteatomas, well known for their property of continued growth and extension into the middle ear spaces. Or, the ulcerated mucosa may be replaced by suppurating granulations with underlying progressive necrosis of bone. Finally the ulcerated middle ear mucosa may heal with adhesion formation and permanent interference with the proper function of middle ear structures.

For many years, surgery in chronic suppurative otitis media was directed to control of progression of middle ear necrosis. To obtain a dry and safe ear, frequently it was necessary to sacrifice the tympanic membrane and a portion of the ossicular chain. No attempt was made to restore any functional mechanism in the middle ear. Occasionally it was possible in limited disease to preserve the drum and ossicles and preserve some degree of useful hearing.

Within the past seven years, significant advances have been made in preserving, restoring, and rebuilding the mechanism of the middle ear, and at the same time controlling chronic inflammation involving this region. This surgery has been made practical by the employment of: (1) Microsurgery, using a binocular wide range microscope equipped with synchronized lighting; (2) Applications of the principles of plastic sur-

gery to rebuild a new tympanic membrane; (3) Application of new knowledge of middle ear physiology; and (4) Use of antibiotics in high dosage locally as well as the usual systemic dosage for quick resolution of middle ear suppuration. This work was pioneered in Germany by Wullstein and Zollner.

Tympanoplastic surgery is of five essential types as proposed by Wullstein. The first is myringoplasty. This method consists of exploring the middle ear and, if necessary, the mastoid antrum to rule out chronic suppuration which may persist after simple plastic closure of a drum perforation. Once the possibility of infection is controlled, the perforation is closed by removal of 2-4 mm. of the outer layer of the drum from the edge of the perforation. A free full thickness graft taken from the skin on the posterior surface of the auricle, or a split thickness graft from the inner aspect of the forearm, is tailored to fit over the perforation of the drum and adjacent prepared bed. The graft is held in place with tampons. Closure of a perforation results in improved hearing because it reduces the amount of sound energy reaching the round window, and renders more efficient the transformation of sound energy from the drum to the oval window.

The second type of tympanoplastic procedure consists of exploration of the mastoid antrum. The epitympanum is opened, exposing the body of the incus and the head of the malleus permanently to the external ear. The ossicles may be necrosed partly but they still are functionally intact. The drum is replaced in whole or in part by an appropriate skin graft. Normal hearing may result.

The third type of tympanoplasty is performed when the ossicular chain is disrupted beyond repair by disease and can no longer transmit sound waves to the oval window. The stapes is intact so that if the drum remnant or graft replacing a destroyed drum is placed directly onto the head of the stapes the latter still acts as an efficient sound transmitter and conducts sound waves from the larger surface area of the drum to the smaller area of the stapes footplate. Attempts are made sometimes to replace a missing stapes and insert an artificial stapes, usually of plastic material, between the drum and the footplate. Hearing may reach the nearly normal level of 2.5 db. in favorable cases.

The fourth type of tympanoplasty is used when the stapes is destroyed so that there is only a movable footplate or membrane in the oval window. Sound transmission from the large surface area of the drum to the oval window is abandoned. The drum remnant or graft replacing a totally destroyed drum is now placed directly onto the promontory, affording sound protection for the round window. The oval window is left open directly to the external ear where it may vibrate from the sound waves directly. Hearing may reach the 25 db. level because of preservation of sound protection to the round window.

We use the fifth type of tympanoplasty operation when the ossicles are destroyed and, in addition, there is a bony or scar tissue fixation of the footplate region in the oval window. A new window or fenestration must be made into the horizontal semicircular canal so that sound waves can set the inner ear fluids into motion again by virtue of two functioning windows.

Essentially the same tympanoplastic procedures are used in cases of congenital malformation of the external and middle ear, once a new external meatus is created and lined with skin.

Reconstructive surgery of the middle ear has opened new vistas for the otological surgeon. Adequate, painstaking, preoperative evaluation and, thorough exploration and evaluation of the pathology found at operation, combined with the use of highly skilled surgical techniques, will correct partially or fully most types of mechanical hearing impairment. We must encourage continued research in otology to help us better define the large number of variables encountered in this complex surgery and to guide us in the selection of the most effective method of surgical correction.

Malignancies of Paranasal Sinuses

DELBERT K. JUDD, M.D., KANKAKEE

Despite the relatively infrequent occurrence of malignancy in the nose and paranasal sinuses, this disease presents one of the most trying problems in otolaryngology. The very fact that it is rare adds to our responsibility in making a correct diagnosis as early as possible. Symptoms in the early stages are vague and indistinct with the result that the malignancy is mistaken for other more common nasal and sinus diseases. This lack of severe symptoms accounts for the fact that a physician is consulted at a late stage of the disease. Equally depressing is that once the patient consults his physician, additional valuable time is lost before diagnosis is made.

Many cases are subjected to the removal of teeth and no small number are treated by antral lavage or minor intranasal surgical procedures without benefit. Chiefly because of these facts the great majority of sinus malignancies do not receive proper treatment until they have advanced to such an extent that cure is practically impossible, even though the most radical procedures are done.

Biopsy offers the only means of establishing a positive diagnosis and should be performed in all cases where suspicion is aroused by X-rays or by atypical tissues encountered during the removal of nasal polyps and supposedly infected sinus mucous membranes. Many cases are first discovered during routine Caldwell Luc operations.

The material presented in this report is based on a review of 39 cases of malignancy of the paranasal sinuses treated during the past 22 years.

The pathologieal distribution of the different tumors in this series is as follows: Squamous cell carcinoma 73 per cent; adenocarcinoma 10.8 per cent; myxosarcoma 5.4 per cent; mixed cell tumors 5.4 per cent; melanoblastoma 2.7 per cent, and reticulum cell sarcoma 2.7 per cent. Six of the tumors originated in the ethmoidal labyrinth and two in the frontal sinus. All others apparently had their origin in the maxillary sinus although several had extended into other sinuses when first seen.

These figures and percentages are easily determined and can be presented as honest facts; but it is a different matter when it comes to reporting end results. There is as yet no answer to the question of what constitutes a cure. The usually accepted 5 year period is unaceeptable when we consider the fact that less than one-half of the 5 year cures are still alive at the end of 10 years. Many of the cases reported in the literature have been observed for periods of less than three or even two years. Aecordingly, before accepting a report of cures, it is necessary to make note not only of the time factor, but also of the number, type, extent, origin, and location of the tumors reported.

SYMPTOMS

Symptoms often are absent or mild until after the neoplasm has filled the sinus and eroded through one or more of its bony walls. Pain is the most common initial symptom. Depending on the direction of extension, other initial symptoms in order of frequency are swelling of the cheek, nasal obstruction, exophthalmos, anesthesia over the area of distribution of the second division of the Vth nerve, and nasal bleeding.

CLINICAL FINDINGS

Swelling of the cheek, upper lip, or infraorbital region is seen in malignancies that erode through the anterior wall of the antrum. When erosion of the floor of the antrum occurs, there is first a rounded swelling of the hard palate inside the alveolar ridge. As the growth progresses, the smooth surface of the mucous membrane of the roof of the mouth is replaced by the irregular, friable, and oftentimes necrotic mass of the tumor

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itself. As the alveolus is invaded, the upper teeth on the affected side loosen. Large sections of the alveolus itself may be so loosened as to be removed at surgery without any effort.

Erosion thru the floor of the orbit permits very rapid invasion of the orbit with edema of the lids, chemosis, upward displacement of the globe, and finally proptosis.

Tumors originating in any of the sinuses may invade the nares, but such extension is particularly true of ethmoid malignancies. Of course, new growths may have their origin in the nasal mucous membrane and invade the sinuses by direct extension. Bleeding and nasal obstruction, almost always unilateral, are the first indication of nasal neoplasms. It is important to remember that any abnormal tissue, including nasal polyps, should be examined microscopically, as a routine procedure.

Metastasis occurs in a high percentage of all cases except adenocarcinoma. A review of the literature revealed no case of metastasis of adenocarcinoma that was verified by histological examination. This is an important fact to remember as you will see by the one case report I have selected to present. Metastasis is found in about 39 per cent of cases of other types of malignancy and the pathways follow lymphatic channels. The most common pathway is posteriorly to the choanal plexus or to the retropharyngeal space to drain into the lateral pharyngeal lymph node. From here the spread is upward to the medial jugular node and to the base of the skull or downward to the deep jugular chain at the bifuraction of the carotid. Usually metastasis follows anterior channels only if cheek, palate, or nasal passage is involved. From these areas, the regular lymph channels of the oral cavity are followed into the submaxillary and carotid bulb nodes.

Prognosis varies considerably depending on the type of tumor, its accessiability, its radiosensitivity, the extent of involvement, and on whether or not metastasis has occurred.

For example, 80 to 90 per cent of malignancies of the paranasal sinuses are squamous cell carcinoma; 40 per cent of these will metastasize—30 per cent even before the surgeon is consulted. In these cases, the hope of complete cure obviously is very poor. On the other hand, adenocarcinoma, the type found in 10 to 15 per cent of the cases, rarely if ever metastasizes. If these lesions are not so extensive as to make surgery impossible the prognosis is good.

TREATMENT

In considering the therapeutic regimen, it is essential to consider 3 chief factors: 1. The site of the lesion, together with the extent of invasion of surrounding structures; 2. Lymphatic extension or metastasis; and 3. Type of tumor with knowledge of its radiosensitivity.

These factors determine our use of the therapeutic measures available—namely, surgery, radiation by X-ray or radium, or a combination of these agents. Unfortunately, a great many cases are inoperable when first seen and the palliative use of radiation is the only treatment we can give.

Contraindications to surgery are advanced age, poor general condition, complicating disease, roentgenographically demonstrable destruction of the base of the skull or pterygoid process, tumor infiltration of the nasopharynx, inoperable lymph node metastasis, generalized metastasis, and refusal by the patient.

In the absence of these contraindications, once the diagnosis of cancer of the nasal cavity or paranasal sinuses is established, radical surgery is indicated. One of the gravest mistakes is to rely upon X-ray therapy alone as a routine in all cases. We do our patients a great injustice when we withhold surgery since it definitely offers the greatest chance for cure used alone or, as generally is the case, in combination with radiation.

Surgery designed to effect cure must be radical. It usually takes a few sad lessons to enable the surgeon to be as ruthlessly radical as the case demands. Several surgical approaches are available depending upon the site and the extent of the tumor. These include: 1. Caldwell Luc; 2. Moure; 3. Denker; 4. Lynch frontal; and 5. Kocher resection of the maxilla.

Generally combinations and modifications of these procedures are necessary.

The classical Caldwell Luc radical antrotomy is not adequate for removal of malignancy as a rule, but may be used to secure drainage and access along with palliative irradiation. This procedure, combined with extensive electrocoagulation, might effect cure in an early case.

The Moure operation, or lateral rhinotomy, affords an excellent exposure. The incision can be

extended upward to include exenteration of all ethmoids and exposure of the frontal sinus. A combined orbital exenteration can be accomplished by lateral extension of the incision. If the roof of the antrum or the lamina papyracea has been penetrated with invasion of the orbit, then the eye and all orbital tissues must be sacrificed. When the palatodental plate is involved, the lip splitting incision is required and the entire maxilla is removed if necessary.

All surgical procedures should be so designed that there remains an adequate opening, either in the palate or canine fossa area, to permit inspection and further therapy if necessary.

The present trend in treatment of neoplastic diseases of the paranasal sinuses is a combination of therapeutic weapons. Deep X-ray therapy can be given to shrink and localize the tumor mass. Radical surgery, using extensive electrocoagulation, is performed at the completion of X-ray treatments. Should recurrences appear they are treated by further electrocoagulation or implantation of radon or radium needles.

Surgical intervention, regardless of the size or position of the tumor should always be supplemented by radium and X-ray therapy. Also, it has been shown that irradiation alone cannot be relied upon to effect cure.

Roentgen radiation can be employed before operation if a clinical and microscopic diagnosis of cancer is established. This is particularly true if the tumor is well advanced. The special advantage of preoperative X-ray therapy is the possibility of obtaining marked regression of a highly cellular and malignant neoplasm. This permits an approach that may offer a better result with electrosurgical measures because of better visualization and less hemorrhage. Any apparent or real improvement, however marked, that follows preliminary radiation, is no excuse for postponing surgery.

Surgery without preliminary irradiation is employed in cases that lack microscopic diagnosis or in early cases in which the tumor is fairly accessible and slow growing. If the tumor is well contained within the sinuses, surgery is done first, but is always followed by radiation. In suspicious cases surgery may be necessary to gain access to tissue for biopsy and in many instances an unsuspected malignant growth is first revealed at an operation done for chronic paranasal sinusitis.

The surgical approach must be extended to meet such an emergency or an extensive involvement, as well as to provide easy access for the satisfactory adjustment of radium applicators. This extension of the operative field usually is supplemented by electrosurgical measures. The base is largely and often entirely bone, or it so closely approximates bone that electrocoagulation offers the most simple and efficient means of destroying the neoplasm. Additional treatment with radium and X-ray is necessary to destroy any tumor that may have infiltrated beyond the bone and may not be recognizable clinically.

Anything short of complete removal or destruction of the growth is a failure. On the other hand, if there is a reasonable chance for complete extirpation and destruction of the tumor the patient should have the benefit of that chance for cure.

Time permits me to present only one case report in some detail. I chose this particular case because it is the only one I have encountered with simultaneous bilateral involvement of all the sinuses and both nasal cavities. No other case could be found in the literature, with bilateral involvement by the same type of tumor. One case was reported by Berger, in which pathologically different tumors were found in the maxillary sinuses after a time lapse of one year. In this case the tumor was an adenocarcinoma and, while local extension was marked, there was great security in knowing that the chance for metastasis was slight or nonexistent.

The patient, a white male farmer was 44 years of age when first seen in July, 1944. He gave a history of nasal obstruction and stated he had had removal of nasal polyps on several previous occasions. The only findings were nasal polyps, and after these lesions were removed he remained symptom free for 15 months. In October of 1945 he returned because of marked swelling of the right upper lid and brow. A mucocele of the right frontal sinus was found to have eroded thru the floor of the sinus into the orbit. This was removed by means of the Lynch radical frontal operation. Microscopic examination was negative for malignancy.

Three years later, in September, 1948, he returned complaining of nasal obstruction and epistaxis and requested removal of nasal polyps. Both nares were found obstructed by hyperplastic tissue that was rather friable and bled easily. X-

rays of the sinuses at that time revealed a marked increased density in all sinuses bilaterally. However, there was no demonstrable bone destruction except that due to the surgical procedure on the right frontal sinus.

A biopsy of the nasal tissue was obtained. This revealed an anaplastic and rapidly growing carcinoma (Grade III). The lesion was thought to be consistent with adenocarcinoma altho squamous cell carcinoma was considered at first. A radical approach was decided upon and on September 28, 1948 the tumor was removed from the right side, using modifications of the Lynch, Moure, and Caldwell Luc procedures. An incision was made beneath the right eyebrow and extended down the right side of the nose to the lateral attachment of the ala. The lip splitting procedure was not included since the alveolous was found to be free of involvement. A long canine fossa incision, together with the external incision, provided ample exposure.

The entire front and medial wall of the maxillary sinus was removed. The cavity was filled with tumor tissue that was scooped out. The floor of the orbit seemed intact. The turbinates and all ethmoid cells were removed, together with the tumor tissue involving the nasal cavity. The anterior wall of the sphenoid sinus and a moderate amount of tumor tissue were removed. The tumor also involved the right frontal sinus and this was taken out. Wide exposure was obtained thru radical removal of bone. Bleeding was quite profuse but blood was replaced by transfusions during the operation. The postoperative course was not too stormy and two weeks later, the same procedure was carried out on the left side.

Microscopic studies of the tissue taken out from both sides revealed a rapidly growing adenocarcinoma. It is believed that the tumor started in the nasal cavities and extended into the paranasal sinuses.

Radiation in the form of radium (needles) and deep X-ray therapy was used extensively following surgery. The needles were packed into the cavities with particular attention to the sphenoethmoid recess region and the roof of the nasopharynx. The external wounds were closed with silk sutures after removal of the radium. No bone transplants were necessary in this particular case since the supporting bony structures necessary to preservation of cosmetically important facial contours were left sufficiently intact. In many cases, however, it is necessary to use tibial bone grafts to reconstruct the infraorbital rim or zygomatic arch. When the alveolus is redentures and replace the roof of the mouth. moved a dental prosthesis can be made to support

Deep X-ray therapy, in tumor dosage, of 4,000 r minimum to all areas was given in divided doses over a period of about a month.

This patient has been under close observation for the 10½ years since the operation. There never has been any evidence of recurrence or metastasis. His chief complaint is dryness of the throat and dried postnasal secretions. Crusts of the nasal cavity are controlled well by occasional saline irrigations. He is still active as a farmer and there is no deformity. His greatest problem has been to convince his neighbors and friends that he really had a malignancy. I finally was persuaded to give him a copy of the pathology report and, to the best of my knowledge, he still carries it with him for the benefit of any unbelievers.

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Magnesium and Arteriosclerosis, Human and Experimental

Earl E. Hellerstein, M. D., Boston

There are similarities between exogenous hyperthyroidism and magnesium deficiency in rats. In addition, it has been well shown in experimental animals that the administration of thyroxine can modify serum lipid values and vascular lipid deposition profoundly.

Therefore, a series of experiments was performed with the original postulate that magnesium deficiency might inhibit the deposition of lipid in the cardiovascular system of the experimental animal, the rat. The results of these experiments showed that the original postulate was of value, though the results were quite the reverse of what was expected. With the particular synthetic diet used, the amount of lipid deposited in the left ventricular valves and, to a far lesser degree in the thoracic aorta (the lipid being measured visually after Sudan IV staining) was greater in animals consuming low magnesium diets than in those consuming high magnesium diets.[1,2] We might well have expected, on the basis of past and current views, that the degree of cardiovascular sudanophilia would have been positively correlated with the serum cholesterol levels. However, the rats with lesser sudanophilia tended to have a greater degree of hypercholesterolemia. Furthermore, by changing the dietary protein from 10 to 20 per cent casein,[1] or by changing the dietary fat from a hydrogenated cottonseed oil to corn oil (unpublished data), we could abolish the antisudanophilic effect of the high dietary magnesium. Lack of a magnesium effect under these changed conditions conceivably may be a function of the accompanying lesser hypercholesterolemia.

Recent studies have shown that the beta-lipoproteins, as determined by paper electrophoresis, in rats whose diets did not contain the hypercholesterolemic agents [cholesterol and cholic acid] were lower in those consuming high magnesium diets than in control rats consuming low magnesium diets.[2] No such difference, though, could be shown between the beta-lipoproteins of the groups of rats consuming atherogenic diets with high and low magnesium, although technical problems may have interfered. Preliminary data in the evaluation of such rat sera, using the ultracentrifugation technique of Gofman, suggest the possibility of finding changes in a parameter of blood lipid that would correlate well with the changes in dietary magnesium and degree of sudanophilia.

Virtually all pathologists agree that the state of the human vascular wall almost certainly has some relation to arteriosclerosis. The disagreements arise as to the importance of these local factors in the etiology or pathogenesis of arteriosclerosis. This is pertinent, for, with magnesium deficiency, there is damage to the arterial wall of various animals.

Bersohn and Oelofse have presented some interesting data relating to serum magnesium and serum cholesterol in humans.[3] Their data showed that the serum magnesium level was significantly higher in the non-Europeans (Bantus) than in Europeans. It is believed that Bantus have a lower incidence of myocardial infarction than do Europeans. They also showed a definite correlation between serum magnesium and serum cholesterol levels in Europeans, high serum magne-

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From the Department of Pathology, Harvard Medical School and the Department of Nutrition, Harvard School of Public Health, Boston, Massachusetts.

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sium levels being associated with low serum cholesterol levels. If this negative correlation between serum magnesium and serum cholesterol were valid, and if it were established unequivocally that an elevated serum cholesterol is of importance in arteriosclerosis and/or coronary thrombosis, a cause and effect relationship between the observed low serum magnesium and high serum cholesterol would not necessarily follow. Our rat experimental data could be interpreted as both agreeing and disagreeing with their findings. On one hand, at suboptimal levels of magnesium, the inclusion of cholesterol and cholic acid in our usual synthetic diets tended to increase the magnesium deficiency as measured by serum magnesium and oxidative phosphorylation of myocardial mitochondria. On the other hand, rats consuming atherogenic diets with high magnesium tended to have higher, not lower, serum cholesterol levels than did those on the low magnesium diet.

The relationship between magnesium and cardiovascular disease is suggested more directly in the material presented by Malkiel-Shapiro et al.[4] They have reported that after treatment with parenterally administered magnesium sulfate, 20 of 22 patients suffering from coronary artery disease showed marked improvement in their clinical condition and 14 of these 22 showed a dramatic improvement in the lipoprotein patterns — i.e., there was a sharp drop in the percentage of beta-lipoproteins.

Brown et al. reported on 186 clinically healthy 45-59 year-old white American males and 39 patients of the same age group hospitalized for acute myocardial infarction.[5] The sera of the healthy group were selected arbitrarily so as to cover a wide range of cholesterol levels. No correlation was found between serum magnesium and various serum lipid fractions — i.e., cholesterol, total lipids, alpha-lipoproteins, or beta-lipoproteins. No difference in serum magnesium levels was found between the infarct group and the clinically normal group. No significant difference between serum magnesium levels was found but there was a highly significant difference between serum cholesterol levels of term mothers and their babies.

Jankelson also could demonstrate no significant correlation between serum cholesterol and serum magnesium levels in adults.[6]

It should be emphasized that a normal serum magnesium does not exclude the possibility of magnesium deficiency.

Since magnesium deficiency uncouples oxidative phosphorylation in rat myocardial mitochondria, it may be that a beneficial effect (if there is one) of magnesium parenterally administered to patients with ischemic heart disease would be on the myocardial cell, rather than on the vessels or serum.

On the basis of available experimental and clinical evidence, the thesis that magnesium metabolism is important in the prevention or treatment of human cardiovascular disease appears to be interesting although tenuous. Further animal and clinical investigation on magnesium and cardiovascular disease is indicated.

REFERENCES

1. Vitale, J. J.; White, P. L., Nakamura, M.; Hegsted, D. M.; Zamcheck, N.; and Hellerstein, E. E.: Interrelationships Between Experimental Hypercholesterolemia, Magnesium Requirement, and Experimental Atherosclerosis, J. Exper. Med. 106:757, 1957.
2. Vitale, J. J.; Hellerstein, E. E.; Hegsted, D. M.; Nakamura, M.; and Farbman, A. B.: Studies on the Interrelationships Between Dietary Magnesium and Calcium in Atherogenesis and Renal Lesions, Am. J. Clin. Nutrition 7:13, 1959.
3. Bersohn, I., and Oelofse, P. J.: Correlation of Serum-Magnesium and Serum-Cholesterol Levels in South African Bantu and European Subjects, Lancet 1:1020, 1957.
4. Malkiel-Shapiro, B.; Bersohn, I.; and Terner, P. E.: Parenteral Magnesium Sulfate Therapy in Coronary Heart Disease. A Preliminary Report on its Clinical and Laboratory Aspects, Medical Proceedings 2:455, 1956.
5. Brown, D. F.; McGandy, R. B.; Gillie, E.; and Doyle, J. T.: Magnesium-Lipid Relations in Health and in Patients with Myocardial Infarction, Lancet 2:933, 1958.
6. Jankelson, O. M.; Vitale, J. J.; and Hegsted, D. M.: Serum Magnesium, Cholesterol, and Lipoproteins in Patients with Atherosclerosis and Alcoholism, Am. J. Clin. Nutrition 7:23, 1959.

Clinical Use of Glucagon in Juvenile Diabetes Mellitus

HOWARD S. TRAISMAN, M.D., AND ALVAH L. NEWCOMB, M.D. CHICAGO

Glucagon is the hyperglycemic, glycogenolytic factor of the pancreas. It was discovered in 1923 by Murlin and associates.[1] Staub and associates crystallized it in 1953.[2] Glucagon is a protein polypeptide, chemically similar to crystalline insulin. The chemical properties and physiology of this drug have been described and summarized by Van Itallie.[3]

There is no definite proof as to the site of origin of glucagon, but it is believed to be in the alpha cells of the pancreas and in cells resembling alpha cells in the gastric and duodenal mucosa. To date there is no conclusive evidence that glucagon has any primary physiologic action other than increasing the blood sugar. Presumably this occurs because it activates the liver phosphorylase system thus increasing glycogen breakdown in the liver.[4]

Much has been written on the clinical uses of glucagon in patients with diabetes mellitus, glycogen storage disease of the liver, spontaneous hypoglycemia, and psychiatric patients with induced insulin coma.[5,6] Glucagon causes a significant rise in blood sugar in five minutes, which demonstrates its rapid onset of action. Patients in profound insulin shock awaken in 15-20 minutes.[6] Because glucagon can make the blood sugar rise rapidly we decided to give this drug a clinical trial in juvenile diabetes mellitus patients who had severe hypoglycemic reactions.

Glucagon was supplied in two forms by Drs. W. R. Kirtley and A. S. Ridolfo of Eli Lilly and Company, Indianapolis, Indiana. The solution was supplied in 10 cc. vials that were refrigerated constantly (lot number P-60257). The solution was sterile, nonpyrogenic, and contained less than 0.05 U per cc. of insulin. The concentration of glucagon was 1 mg. per cc. This solution has a pH of 2.5, and contains approximately 0.25% phenol. Intravenous or intramuscular routes of administration are recommended in preference to the subcutaneous route, to permit more rapid absorption and action.

The lyophilized form is prepared from crystalline glucagon hydrochloride and contains 1 mg. of glucagon per cc. when reconstituted with the diluting fluid. The diluting fluid is the same fluid used in the preparation of insulin. Both the lyophilized and nonlyophilized glucagon hydrochloride, therefore, have the same dosage.

The purpose of lyophilization is to permit a longer shelf life; glucagon can remain stable on the shelf until it is mixed with the diluent for injection. Lyophilized glucagon should be used within one month after reconstitution.

The usual dosage of glucagon in the lyophilized form is from ¼ to 5 mg. This may be injected either subcutaneously or intravenously. Intravenous administration is most effective, but glucagon still is 70 to 80 per cent effective when given subcutaneously or intramuscularly.

Case Reports

All the juvenile diabetic patients were receiving a weighed diet, and lente insulin in mixture with semi-lente or regular insulins. Glucagon was administered intravenously or intramuscularly in a dosage of 0.50-0.10 mg. per kilogram of body weight.

Case #1: R. L., a 12 year old female developed diabetes mellitus in December, 1950. She has been a brittle patient, and idiopathic major convulsions complicate her diabetic picture. While at the Chicago Diabetes Associations' Camp for diabetic children in August, 1957 she suddenly began to have a convulsion. The blood sugar at the time of the seizure was 300 mg.%. The resident administered 5 cc. of glucagon intravenously. Within five minutes she began to respond; 20 minutes later her blood sugar was 400 mg.%, a rise of 100 mg.%. Though this spell obviously was not hypoglycemic it demonstrates the rapid effect of this drug.

Case #2: C. R., a 6½ year old female developed

From The Children's Memorial Hospital, and Department Pediatrics, Northwestern University Medical School, Chicago, and Evanston Hospital, Evanston, Illinois.

diabetes in January, 1957. She had had many episodes of hypoglycemia. A bottle of glucagon was given to the mother with instructions as to dosage, when to use it, and the site of intramuscular injection. An insulin reaction occurred on August 8, 1957 at about 4 p.m. It was impossible to give oral carbohydrate but 2.5 cc. of glucagon was injected into the left deltoid muscle. Within five minutes, the patient was alert and able to take oral feedings.

Case #3: S. R., a 4½ year old male developed diabetes in January, 1956. He had frequent episodes of hypoglycemia which necessitated the use of adrenalin. Glucagon was given to the mother with instructions for its use. On five different occasions in the past five months the boy has had insulin reactions in the late afternoon. One cc. of glucagon was given IM in each instance, and within three to five minutes he was awake and able to take oral feedings. The headache he usually had following the injection of adrenalin did not occur after glucagon administration.

Case #4: A newborn male infant of a diabetic mother had a blood sugar of 250 mg.% (Somogyi) at birth. At three hours of age the micro blood sugar was reported "as less than 5 mg.%", and he was in a state of collapse. Being unable to administer glucose in a peripheal vein, 1 mg. of lyophilized glucagon was given intramuscularly. The patient began to respond in about five minutes while a cut-down was being done. Twenty minutes later, prior to starting an infusion of 5 per cent dextrose solution, another blood sugar was drawn, which was 58 mg.%.

DISCUSSION

Glucagon was administered intravenously or intramuscularly in a dosage of 0.05-0.1 mg. per kilogram of body weight. Its hyperglycemic effect was observed clinically and chemically in case No. 1 and case No. 4, and clinically in cases 2 and 3. While glucagon and epinephrine produce a similar clinical response, they have quite different actions. The only similar action of these two substances is that they promote liver glycogenolysis by activating liver phosphorylase. When epinephrine is injected, it increases lactic acid production in the liver and muscle. Administering glucagon does not increase lactic acid and may even produce a slight fall.

Epinephrine stimulates muscle glycogenolysis and may decrease peripheral glucose utilization. This does not occur when glucagon is given. Epinephrine also is a weak stimulant of ACTH production and has many autonomic and hemodynamic actions. Glucagon has so such effects.

Van Itallie states that after epinephrine is injected, the muscles are depleted of glycogen and the respiratory quotient falls.[3] He believes that "its role cannot be simply to transfer glucose from the liver to the periphery since its action tends to exclude glucose from the extrahepatic tissues." It may be that as an emergency mechanism to help combat hypoglycemia, epinephrine acts to insure maintenance of the supply of carbohydrate to the central nervous system.

From our observations we believe that glucagon is an excellent hyperglycemic agent. It may be used by intelligent parents of juvenile diabetics. Glucagon is a valuable adjunct in the management of brittle juvenile diabetics and the hypoglycemic infant of the diabetic mother.

CONCLUSIONS

We concur with other investigators that glucagon is an effective hyperglycemic agent. It is a valuable home aid for use by select, competent parents to treat hypoglycemia in juvenile diabetics who cannot swallow oral feedings. Its use for the hypoglycemic infant of the diabetic mother warrants further investigation.

6354 N. Broadway

REFERENCES

1. Murlin, J. R.; Clough, N. F.; Gibbs, R. B.; and Stokes, H. M.: Aqueous Extracts of Pancreas: 1. Influence on Carbohydrate Metabolism of Depancreatized Animals, J. Bio. Chem. **56**:253 (May) 1923.
2. Staub, A.; Linn, L.; and Behrens, O.K.: Purification and Crystallization of Hyperglycemic Glycogenolytic Factor, Science **117**:628 (June 5) 1953.
3. Van Itallie, T. B.: Glucagon: Physiologic and Clinical Considerations, New England J. Med. **254**:794 (Apr. 26) 1956.
4. Sutherland, E. W.: The Effect of the Hyperglycemic Factor of the Pancreas and of Epinephrine on Glycogenolysis. VI. Mechanisms of Hormone Action. Recent Progress in Hormone Research, New York, Academic Press, Inc., **5**:441, 1950.
5. Carson, M. J., and Koch, R.: Clinical Studies with Glucagon in Children, J. Pediat. **47**:161 (Aug.) 1955.
6. Schulman, J. L., and Greben, G. E.: The Effect of Glucagon on the Blood Glucose Level and the Clinical State of Marked Insulin Hypoglycemia, J. Clin. Invest. **36**:74 (Jan.) 1957.

The Physician's Lien

Walter L. Oblinger, Associate Counsel, Springfield

One of the most vexatious of medicolegal problems, so far as the average medical practitioner is concerned, has been the nonpayment of medical fees for services rendered in personal injury suits. Many members of this society have raised the question as to why a physician may not have a lien on the cause of action and be protected in the final settlement of the patient's lawsuit.

The solution to this problem was presented to the Illinois General Assembly by the Illinois State Medical Society this year in SB 1001, which was adopted by both houses. It was signed by the Governor on July 23, 1959. Now the physician, along with the attorney and hospital, each has a lien in the maximum amount of one-third of any recovery of the patient.

SB 1001 is as follows:

"Section 1. Every licensed physician practicing in this State who renders services by way of treatment to injured persons, except services rendered under the provisions of the Workmen's Compensation Act or the Workmen's Occupational Diseases Act, shall have a lien upon all claims and causes of action for the amount of his reasonable charges up to the date of payment of such damages.

"Provided, however, that the total amount of all liens hereunder shall not exceed one-third of the sum paid or due to the injured person on the claim or right of action, and provided further, that the lien shall in addition include a notice in writing containing the name and address of the injured person, the date of the injury, the name and address of the licensed physician practicing in this State, and the name of the party alleged to be liable to make compensation to such injured person for the injuries received, which notice shall be served on both the injured person and the party against whom such claim or right of action exists.

"Notwithstanding any other provision of this Act, payment in good faith to any person other than the physician claiming or asserting such lien prior to the service of such notice of lien shall, to the extent of the payment so made, bar or prevent the creation of an enforceable lien. Service shall be made by registered or certified mail or in person.

"Section 2. The lien of any such licensed physician practicing in this State shall, from and after the time of service of the aforesaid notice, attach to any verdict, judgment, or decree secured in any suit or action by the injured party based on the negligent or wrongful act, and to any money or property which may be recovered by compromise settlement, or in any suit or action brought by such injured person on account of such claim or right of action. In case of death of the injured person, the lien shall attach to any money or property which may be recovered by compromise settlement, suit, or action on account of injuries not resulting in the death of the injured person, or to any verdict, judgment or decree in any suit or action brought by the estate of the injured person against any other person for the recovery of damages on account of injuries not resulting in the death of the injured person.

"Section 3. Any party to a cause pending in a court of record against whom a claim shall be therein asserted for damages resulting from injuries shall, upon request in writing, be permitted to examine the records of the physician in reference to the examination and treatment of the injured person. Any physician claiming a lien under this Act shall, within 10 days of being so requested in writing by any such party, furnish to such party or file with the clerk of the court in which the cause is pending, a written statement of the nature and extent of the injuries sustained by and the treatment given to the injured person by such physician and the history, if any, as given by the injured person, so far as shown by the records of the physician as to the manner in which the injuries were received.

"Section 4. Any party against whom a claim

shall be therein asserted for damages resulting from injuries, shall, upon request in writing, be permitted to examine the records of the physician in reference to the examination and treatment of the injured person. Any physician claiming a lien under this Act shall, within ten days of being so requested in writing by any such party, furnish to such party, a written statement of the nature and extent of the injuries sustained by and the treatment given to the injured person by such physician and the history, if any, as given by the injured person, so far as shown by the records of the physician as to the manner in which the injuries were received.

"Section 5. Should any physician fail or refuse to give or file a written statement in conformity with and as required by Sections 3 and 4 hereof, after being so requested in writing in conformity with Sections 3 and 4 hereof, the lien of such physician shall immediately become null and void.

"Section 6. On petition filed by the injured person or licensed physician practicing in this State, any court of competent jurisdiction shall, on written notice to all interested adverse parties, adjudicate the rights of all interested parties and enforce their liens; provided that nothing herein contained shall affect the priority of any attorney's lien under 'An Act creating attorney's lien and for enforcement of same' filed June 16, 1909, as amended; provided further, that nothing herein contained shall give priority to liens of nonprofit hospitals and hospitals maintained and operated entirely by a county rendering treatment and maintenance to injured persons, approved July 19, 1939, as amended."

SB 1001 was modeled after the Hospital Lien Law and bears a marked resemblance to it. It differs from the Hospital Lien Act in that the lien will not attach to claims arising under the Workmen's Compensation or Occupational Diseases Acts. This is because those acts contain provision for payment of medical services. It should be noted that in order for the lien to come into being, the physician is required:

1) to serve notice in writing on both the injured person and on the party against whom the claim or right of action exists, setting out:

(a) name and address of the injured person,

(b) the date of the injury,

(c) name and address of the licensed physician,

(d) name of the party alleged to be liable to make compensation to the injured person for the injuries received;

2) within 10 days after receiving a request in writing from the person against whom the claim for damages is asserted, furnish a written statement of the nature and extent of the injuries sustained by, and the treatment given to, the injured person by such physician, and the history, if any, as given by the injured person so far as shown by the records of the physician as to the manner in which the injuries were received. Failure or refusal to file such a written statement results in the loss of the lien.

SB 1001 is a statutory lien which attaches to the patient's claim or cause of action, known in the law as a *chose en action*. It did not exist at common law and in fact, differs from common law liens in that the creditor does not have possession of the property. It depends solely upon the language of the statute and can be enforced only by compliance with the statute.

It will be noted that the physician's lien is made subordinate to the attorney's lien. It might be well to explain that the lawsuit or cause of action is the work product of the attorney. Without the attorney's services, the claim never comes to fruition and hence there are good and valid reasons to give first recognition to his lien. It will be noted that the attorney's lien is limited to one-third of the settlement or recovery. While the language of the statute recognizes the existence of the hospital lien it should be noted further that it does not have priority over the physician's lien. Nor does the statute give the physician's lien priority over the hospital lien. It is suggested that no difficulty or conflict should arise in connection with these liens because each is limited to one-third of the recovery of the patient-client.

It is possible that the physician's fee for services to the patient may exceed one-third of the patient's settlement or recovery, in which case the physician will be protected only to the extent of one-third thereof. In this situation, it will behoove the physician to employ other means to protect himself. If he is forewarned that there is going to be a settlement and the patient is not co-operative, we would suggest that an attorney be consulted so that legal action can be instituted—possibly attachment, garnishment, etc.

The General Assembly also passed HB 1280 which was subsequently approved by the Governor. This bill created a physician-patient privileged communication in the form of a prohibition on the physician from making any disclosures of information received in treating the patient. The Act contains exceptions to the privilege, one of which provides that there shall be no privilege in civil suits brought by or against the patient. A strict construction of HB 1280 would seem to limit the creation of the lien provided for by SB 1001 until after the patient has filed his lawsuit. One of the problems sought to be solved herein, however, is the situation where the patient or his attorney settles the suit without going to Court. Section (2) above specifically states that "the lien of any such licensed physician practicing in this State shall, from and after this time of service of the aforesaid notice, attach to . . . any money or property which may be recovered by compromise, settlement . . ." Section (1) provides that "every licensed physician . . . shall have a lien upon all claims and causes of action . . ." Section (4) refers only to the claim for damages and provides the means for disclosing the physician's records. It would appear therefore that the physician's lien attaches to the claim on which suit has not been filed as well as on a cause of action and that section (4) in effect is another exception to HB 1280. The courts might also find that since SB 1001 was signed on July 23, 1959, it in effect amends HB 1280 which was approved by the Governor on July 22, 1959. In the circumstances, we are of the opinion that SB 1001 is not affected by HB 1280 so far as the creation of the lien is concerned. We wish to point out, however, that the physician must not furnish any information not specifically authorized by SB 1001, particularly any history of the injury related by the patient at the time of treatment, unless such statements are spread on the physician's records. We believe that as time passes, attorneys for claimants will in the interest of their clients be more zealous in their efforts to protect the physician's interests in this situation and that the physician's lien will not be widely used. Most responsible attorneys now seek to protect the physician's interest and many insurance companies make one of their settlement checks out to the physician and the patient.

A suggested form of physician's lien notice is as follows:

NOTICE OF LIEN
In favor of John M. Jones, M.D.
1424 Chestnut Street
Springfield, Illinois

Dated this ——— day of ————, 19—.

TO: ————————
————————
————————
————————

I am advised that ————————, whose address is ————————, has a claim, right, or cause of action against you for injuries received, resulting from an accident on or about ————————.

You are notified that I claim a lien upon such claim, right, or cause of action for reasonable charges for medical services rendered said ——— ——————— on account of said injuries, the total amount of such lien not to exceed one-third (1/3) of any sums due or paid to such injured person by compromise, settlement, or satisfaction after the satisfaction of any attorney's lien, if any.

This lien is claimed pursuant to an Act providing for a lien for physicians rendering treatment to injured persons approved July 23, 1959 (Chap. 82, Sec. 101.1 Ill. Rev. Stats., 1959.)

Money paid in settlement of this claim or in settlement or payment of any judgment or decree on this claim is subject to this lien, and before making settlement, you should consult with me and see that this lien is satisfied.

————————
Signature

(This notice to be served on both the injured person and the parties against whom such claim or right of action exists, by registered mail or in person.)

CASE REPORTS



Extragenital Chorioepithelioma of the Male Report of Two Cases

JERRY KAYNE, M.D., CHICAGO

Chorioepithelioma of the male usually is a primary tumor of the testes. Now and then, however, it occurs as an extragenital primary lesion in such locations as the anterior mediastinum,[1] retroperitoneal tissues,[2,3] and urinary bladder.[4] Microscopic study of serial block sections is essential to rule out the testes as the origin of a chorioepithelioma. It has been felt that a primary testicular lesion may have undergone involution or regression and resulted in scar tissue, small cysts, or fibrosis. Therefore, a thorough study of the testes is essential, before the diagnosis of extragenital chorioepithelioma can be made. The following two cases are added to the present 16 accepted cases.

O. S., a 46 year old white male, was first seen March 18, 1950. He was a well nourished and well developed individual, 74 inches tall, and weighing 236½ pounds. His only complaint was the sensation of a mass in the left neck region of only one week's duration. Past history was essentially negative, except for bilateral herniorraphy in 1920 and hemorrhoidectomy in 1945. The only positive finding revealed by complete physical examination was a walnut sized, firm, nonmovable mass, not tender, in the left lower neck region. There were diffuse soft rales and increased breath sounds throughout both lungs.

Because it was felt that this was a malignant metastatic lesion without any obvious primary, the patient was hospitalized at Edgewater Hospital for further diagnosis. Two days after admittance, the mass in the neck had increased in size to that of a lemon. The following were the essential pre-operative findings: blood count was normal; electrocardiagram revealed right bundle branch block; urinalysis revealed 10-11 R.B.C. per H.P.F.; X-ray of the chest revealed multiple round metastatic lesions in both lung fields resembling a carcinomatous metastasis.

A biopsy of the mass in the neck under local anesthesia was performed by Dr. Philip Kaplan, March 21, 1950, in which he removed a large portion of the tumor through a left supraclavicular incision. The pathological report revealed the tissue to be metastatic carcinoma markedly

anaplastic, probably a chorioepithelioma. The Aschhiem-Zondek test performed at that time was strongly positive.

Repeated X-ray films of the chest taken several days apart revealed a marked and rapid increase in the size and number of the metastatic lesions. They began to have a soft round snowball-like appearance. Within 2 days after admittance the patient developed a harsh severe cough with marked pain in both lung fields. Three weeks after the patient was first seen he complained of pain in both breasts. The breasts enlarged rapidly and became tender. There was a rapid downhill course with increasing chest pain, cough, dyspnea, and episodes of bloody expectoration. Patient died April 23, 1950, five weeks after first seen.

AUTOPSY REPORT

Autopsy revealed the following positive evidence: A mass 10½x7x6 cm. in the retroperitoneal space just below the bifurcation of the aorta in the greater pelvis. It was hemorrhagic, granular, somewhat nodular, and slightly soft. Microscopic examination revealed the mass was infiltrating into nearby muscle tissue and resembled chorioepithelioma. The mass in the neck from which the biopsy had been taken was similar in nature and microscopic structure. Regional lymph nodes were not involved. Metastatic lesions were found in both kidneys, lungs, and adrenals. Gynecomastia was present. Careful examination of the prostate, seminal vesicles, spermatic cord, epididymus, and testes failed to reveal the presence of any tumor. Numerous microscopic sections of the testes failed to reveal any deviation from normal.

J. O., a white male, aged 60, well developed, weight 186 pounds, 66 inches tall, was first seen Nov. 16, 1956, with a complaint of dyspnea of two weeks' duration. There was a slight nonproductive cough of similar duration of which the patient did not complain. Complete physical examination was essentially negative except for rales, harsh breath sounds, and diffuse wheezes throughout both lungs. X-ray examination at that time revealed multiple small snowball-like lesions throughout both lungs. These findings were so strikingly similar to those of case I, a diagnosis of chorioepithelioma was considered immediately.

The patient was hospitalized at Edgewater Hospital Nov. 23, 1956 for further examination and work-up. Aschheim-Zondek test was strongly positive. Blood count, urinalysis, I.V.P., and stool were essentially normal. Blood chemistry studies and cephalic flocculation were normal. Blood pregnandiol was extremely high. Sputum was positive for cancer cells. Shortly after hospitalization, repeated X-rays of the chest revealed that the metastatic lesions were becoming larger and they have a snowball-like appearance. The patient's breasts became enlarged and tender. Patient died Dec. 23, 1956, five weeks after first being seen.

AUTOPSY REPORT

Autopsy examination revealed metastatic chorioepithelioma of the pericardium, pleura, lungs, liver, and peribronchial lymph glands. No primary tumor was found. An extensive examination, gross and microscopic of the kidneys, epididymis, and testes revealed no abnormal findings.

SUMMARY

1. Two cases are presented of extragenital chorioepithelioma in males, as proved by careful dissection and microscopic examinations of the urogenital system, with no primary lesion evident.

2. Findings in common were gynecomastia, positive Aschheim-Zondek test, and rapid downhill course with expiration within five to seven weeks from the time the first symptom was noted.

3. The pulmonary symptoms due to rapid metastases to the lungs with typical large snowball-like lesions were so obvious that diagnosis was suggestive on X-ray findings.

REFERENCES

1. Caes, H. J., and Cragg, R. W.: Extragenital Choriocarcinoma of the Male with Bilateral Gynecomastia, U.S. Naval M. Bull. 47:1072 (Nov.-Dec.) 1947.
2. Heaney, H. C.: Extragenital Choriopithelioma in Male, Cancer 19:22-30 (Sept.) 1933.
3. Erdman, L. F.; Brown, H. A.; and Shaw, H. W.: Chorioepithelioma in Male of Extragenital Origin, Urol. & Cutan. Rev. 45:1-6 (Jan.) 1941.
4. Weinberg, T.: Primary Chorioepithelioma of Urinary Bladder in Male: Report of One Case, Am. J. Path. 15: 783-796 (Nov.) 1939.

Clinical-Surgical Conferences



Hepatic Abscess

Department of Surgery
Cook County Hospital

Moderator:
Robert J. Freeark, M.D.
Director of Surgical Education
Cook County Hospital

Discussants:
Leonard Cardon, M.D.
Associate Professor of Medicine, Northwestern University Medical School; Attending Physician, Cook County and Mt. Sinai Hospitals

E. Lee Strohl, M.D.
Associate Clinical Professor of Surgery, University of Illinois College of Medicine; Attending Surgeon, Presbyterian-St. Luke's and Cook County Hospitals

Willis G. Diffenbaugh, M.D.
Associate Clinical Professor of Surgery, University of Illinois College of Medicine; Associate Attending Surgeon, Presbyterian-St. Luke's and Cook County Hospitals

Dr. Robert J. Freeark: Abscesses of the liver seldom are encountered in present day surgical practice. The widespread use of antibiotics in treating abdominal infections undoubtedly is responsible for the rarity of these lesions. But they still occur. Always a diagnostic problem, the modifications in their clinical course resulting from antibiotic therapy intensify their insidious and baffling characteristics. Two recent experiences with the problem on the wards of Cook County Hospital have served as timely reminders of their continued occurrence.

Any patient with hepatic abscess needs an astute diagnostician. Of equal importance to recovery is a surgeon skilled in the therapy of this condition. Mindful of this need, we have assembled for this conference three members of our own staff who are eminently qualified to discuss the problem. Dr. Leonard Cardon has long been a highly regarded internist on the medical wards of this hospital. His diagnostic skill, broad experience, and therapeutic wisdom are unsurpassed in an institution long revered for its brilliant clinicians. I well remember, as an intern at this hospital, the rewards of rounds with Dr. Cardon.

Our surgical department is represented by a team whose individual and collective reputations would be difficult to duplicate. Dr. E. Lee Strohl and Dr. Willis G. Diffenbaugh are completing their first year as staff members of this hospital. Already they have earned the respect and admiration of the interns, residents, and staff members. These outstanding surgeons, with a unique facility for teaching and clinical research, have authored numerous valuable contributions in the surgical literature. Recently they reviewed the subject of hepatic abscess as it is encountered in the private institution in which they worked. We are pleased to have them on our staff and as discussants in this conference.

Case 1.

Dr. Roy Cooksey (Surgical Resident): This 16 year old Negro male car washer entered Cook

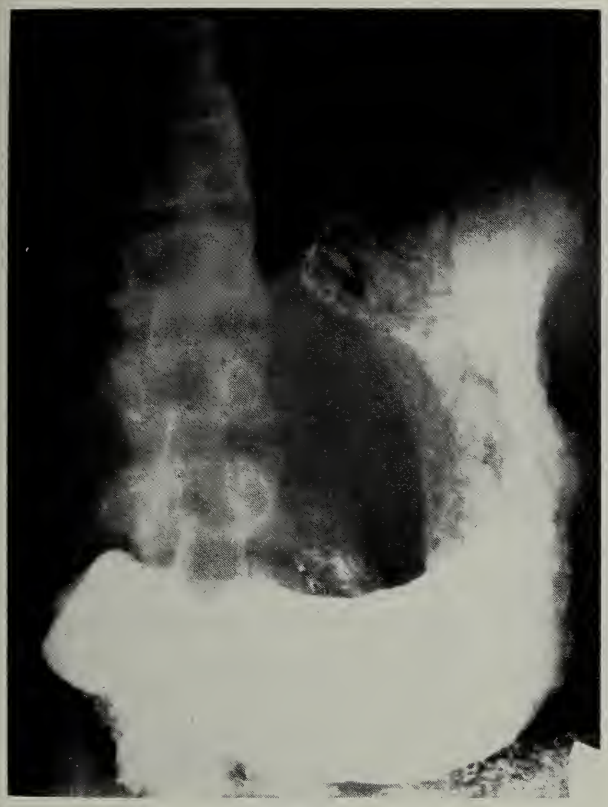


Figure 1



Figure 2

County Hospital on July 18, 1959, after four days of acute epigastric pain that was sharp, constant, and nonradiating. No relationship was elicited to food ingestion or position changes. Anorexia had existed for the four days prior to admission, but vomiting, diarrhea, chills, and fever were denied. His health had been good with the exception of a hospitalization eight years ago for a similar pain associated with jaundice that was diagnosed as hepatitis. The patient admitted to periodic alcoholic excesses.

Physical examination was not remarkable except for a large, poorly delineated mass in the right upper quadrant which felt cystic and was extremely tender. Vital signs were normal with the exception of a rectal temperature of 102° F. on admission.

The hemoglobin was 97 per cent, white blood cell count 9,950 with 78% neutrophils and 22% lymphocytes. Urinalysis, liver profile, cholecystogram, and serum and urine amylase were normal. Barium studies revealed an epigastric mass displacing the stomach laterally and inferiorly and the left half of the colon downward (Figures 1, 2, and 3.) Proctoscopic examination was negative.

Fever and abdominal tenderness responded

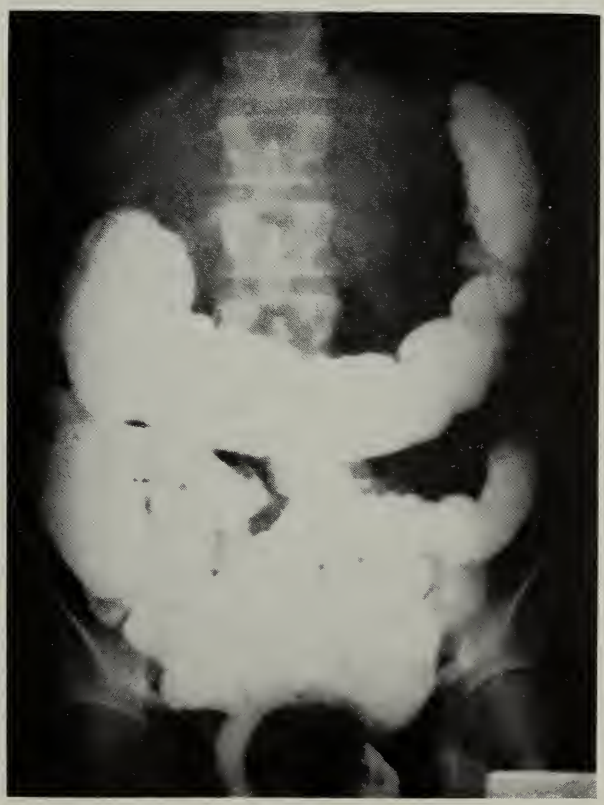


Figure 3

slowly to large doses of terramycin. On August 5, 1959 exploration was carried out with a tentative diagnosis of pancreatic pseudocyst.

Dr. Freeark: We suffered greatly from gunbarrel vision in this case and could see little else than a pancreatic pseudocyst with secondary infection as the cause of this man's difficulty. A pancreatic mass seemed certain with his history of chronic alcoholism, displacement of the stomach on X-ray study suggesting a cyst presenting through the gastrohepatic omentum, together with very fine calcifications just anterior to the first lumbar vertebral border. The normal amylase determinations were disturbing but not incompatible with this diagnosis. The surgeons were somewhat miffed at the time of exploration when, on enlarging the left paramedian incision to the upper part of the abdomen, they came into a pocket of pus. On further exploration, it was found to occupy the left side of the liver and even extended over to the right lobe.

We admit to a diagnostic and perhaps therapeutic error. Dr. Cardon, will you give us your impression of this case and your experience in this condition?

Dr. Leonard Cardon: As Dr. Freeark has said, liver abscess is not a condition commonly seen in private practice. In a practice of 25 years I have had occasion to see but a half a dozen cases. The history in this case is as little related to the diagnosis of liver abscess as you would want to have it. Most of the things we do expect to have are not present. Actually, all we have is temperature on admission and a tender mass in the epigastrium. Usually we expect to find marked leucocytosis and neutrophilia. The only suggestion of what was really going on here was given by the roentgenogram where, in hindsight, it seems that the mass is continuous with and assumes the outline of the liver. When you have an abscess of the liver, the findings on X-ray are like this. There may be some pressure defect on the lesser curvature of the stomach and sometimes on the duodenum. Liver abscess might have been considered because of the extension and general shape of the mass. Otherwise the clinical picture was not at all what we would expect with liver abscess.

Dr. Freeark: Dr. Diffenbaugh, would you interrupt here to throw a little light on the origin of liver abscess and then we will get back to the diagnostic problems it presents?

Dr. Willis G. Diffenbaugh (at the blackboard): Pyogenic liver abscesses may come about in five different ways. Most frequent is by spread through the portal venous system, which drains all areas of the abdomen where suppuration is encountered. In the light of the numerous infectious problems occurring in the abdomen, it is surprising that liver abscess is not more prevalent. Exploration in a suppurative area must shower the liver with septic emboli. A second route of infection is by bacterial spread through the hepatic arterial system, as might occur in subacute bacterial endocarditis. Third, suppuration in the bile ducts may lead to liver abscess. The fourth route of infection is through the lymphatics from neighboring organs, such as the gall bladder, when these organs are the site of infection. A fifth means of producing pyogenic liver abscess is trauma, with destruction of liver tissue and secondary infection of this damaged tissue by the bacterial flora of the liver.

The surgeon here encountered a liver abscess, probably unilocular, that could be drained and cured. Pyemic and pylephlebitic abscesses usually are small and multiple and are best treated medically with high doses of antibiotics. Cholangitic abscesses usually are multiple and small also but they may heal with surgical drainage of the infected gall bladder and biliary tract in addition to antibiotic therapy.

Dr. Freeark: We will admit that this case is atypical. Dr. Cardon, what do you usually encounter in the clinical picture of hepatic abscess?

Dr. Cardon: In most cases there will be fever, chills, pain, and tenderness of the hepatic area; the liver usually is enlarged and there is often some guarding of the right upper rectus muscle. Abdominal findings are especially likely to be present if there is moderate or marked leucocytosis and if neutrophilia and positive X-ray findings are present. If the abscess is in the right lobe there is elevation, irregularity, and limited mobility of the right diaphragm, but on the left side there may be a pressure defect on the stomach and duodenum; and gas shadows or an air fluid level may be seen. We had a case here at County some years ago in which one of the attending men, on examining what was thought to be empyema of the chest, noted that the central portion of the area of dullness had a tympanitic quality and he diagnosed a liver abscess, which

was correct. So a tympanitic quality on percussion of an area of consolidation might be important.

This is all very good on paper but we must remember that enlargement of the liver often is upward and many abscesses occur in the dome of the liver, associated with pleural fluid and empyema, and you may not feel the liver edge on abdominal palpation or see that enlargement of the liver shadow on roentgenogram. If the enlargement of the liver is downward, then often there is associated tenderness and abdominal rigidity which preclude palpatory evidence of the liver edge. You will not feel the liver enlargement unless you know about feeling with both hands, one on the back and one on the front. Or, if a mass is detected, it may be misinterpreted as a large gall bladder. Many cases have been operated upon with a provisional diagnosis of empyema of the gall bladder.

Diagnosis of liver abscess is difficult and usually some other condition is considered more likely. It may be mistaken for renal or perirenal abscess, subphrenic abscess, carcinoma of the stomach, leaking duodenal ulcer, appendiceal abscess, typhoid fever, hepatitis, or some other acute abdominal catastrophe. After a period of a week or more of observation, and particularly if the patient is not too sick to have X-ray study, then diagnosis can be established in most cases. Absence of jaundice is important because it rules out cholangitis, and absence of a palpable gall bladder tends to rule out an acute gall bladder or pericholecystic abscess.

In the differential diagnosis of hepatic abscess, pylephlebitis must be considered. You may have a history of suppurative appendicitis or some other disease of the gastrointestinal tract in which the onset is acute with violent fever, chills, sweats, pain, and tenderness extending upward from the region of the appendix toward the liver. The liver tends to be enlarged and more tender in pylephlebitis; leucocytosis and signs of sepsis are more marked, and jaundice is more frequent than in a solitary abscess. In solitary abscess, jaundice is rare except terminally. Also in a solitary abscess there is a more insidious onset. There may be no discoverable antecedent focus of infection in the abdomen. An antecedent focus may be apparent in some cases.

We had a Negro boy years ago, about 17 years of age, who had appendicitis and abscess formation that had been operated upon one year previously. He came in with a huge mass, tender, fluctuant, adherent to the skin, located in the epigastrium. When that occurs you can use a needle to explore and find pus and make the diagnosis. In another case a man was shot some 20 years previously. He came into the hospital and died, and postmortem showed a huge liver abscess. Postmortem roentgenograms showed fragments of a bullet in the wall of the abscess. This is like the brain abscesses seen in soldiers hit by shrapnel; the condition may remain dormant for 10 to 20 years until an acute flare-up occurs and the patient dies of an acute brain abscess.

As for amebic abscess, you often cannot differentiate it from a solitary pyogenic abscess. It usually is considered to be single, but in half the cases multiple abscesses exist. The onset is insidious, the course is more chronic, and the patient is not so acutely ill as in hepatic abscess. Chills are not as common and symptoms may not appear for a long time. The most important thing in the diagnosis is a history of dysentery and the finding of amebas or cysts in the stool or sputum. However, in one patient with a history of dysentery for months, chills, fever, sweats, high alkaline phosphatase before he became jaundiced, there was a large mass in the right upper quadrant that was interpreted as liver. The laboratory reported cysts in the stool and the diagnosis was made of amebic abscess of the liver. He was operated upon, and at surgery was found to have carcinoma of the head of the pancreas. Response in such a situation to emetine or chloroquin as a therapeutic test may be decisive.

Subphrenic abscess gives more pain and it radiates to the scapula or tip of the shoulder. Chills and fever are less common. X-ray study is more helpful because the diaphragmatic motion is absent. In fact, there is no mobility of the diaphragm at all, in contrast to hepatic abscess where mobility is only impaired.

Gall bladder disease frequently comes under consideration. You may have a history of previous attacks; constitutional symptoms are not so marked but nausea and vomiting are more common and there is localized tenderness. You may be able to feel the gall bladder, so that differentiation from liver abscess is not difficult. You do

not have liver enlargement unless you misinterpret the palpable gall bladder as liver edge. Common duct stone with cholangitis produces more nausea, vomiting; and jaundice; less enlargement and tenderness of the liver; and no significant elevation, irregularity, or immobility of the diaphragm.

You may have to differentiate from pneumonia. There may be chills, fever, sweats, sudden onset, restricted motion of the diaphragm, dullness over the lower chest, dyspnea, cough, and expectoration. So you can see why a diagnosis of pneumonia might be entertained. Again, the question of liver enlargement and upward displacement of the diaphragm is important. If the sputum contains amebas and if it is anchovy sauce in appearance the diagnosis is settled right then.

You must consider also systemic infections such as septicemia, pyemia, subacute bacterial endocarditis, typhoid, infectious mononucleosis, lymphoma, malaria, specific infectious diseases, acute hepatitis, leptospirosis, and miliary tuberculosis.

Echinococcus cyst with suppuration is rare here, but not long ago we had a patient of Greek parentage who had such a huge cyst. I also remember a patient from Palestine who had the picture of Charcot's triad. He was operated upon with a diagnosis of common duct stone, and in that duct there were three small echinococcus cysts moving up and down and producing intermittent jaundice and fever. A recheck of his chart showed 30 per cent eosinophils.

How about exploratory puncture for diagnosis in these cases? It is potentially dangerous because you may infect the pleural or peritoneal cavity as you withdraw the needle from the abscess. However, if the patient is like the 17 year old boy I mentioned with the mass fluctuant and pointing through the skin, you can introduce a needle with little danger. You may be able to do a low thoracentesis and find typical reddish-brown pus with amebas in the pus. Occasionally you might take a chance of exploring the costovertebral angle with a needle. In general, exploratory puncture is avoided except at operation.

What about exploratory laparotomy? You must do this carefully because it can be done several times in the same patient and the abscess will be missed. I want to cite three cases. In one, three operations were done and the liver abscess was missed. The first was the case of a 17 year old white boy in whom perinephric abscess was suspected. He was operated upon by an excellent surgeon. Renal incision was made and no perinephric abscess was found. The incision was extended anteriorily and examination of the gall bladder showed it to be smooth and shiny. The boy was closed up. That was in January 1953. On February 25, 1953, he suffered from continuing chills, fever, sweats, and toxicity, and was operated upon while apparently in extremis — emaciated, febrile, and very ill. At this time a small subhepatic abscess was found at the hilum of the liver. It was drained but the patient did not improve. A third operation was done on March 8, 1953, as a desperate measure. This was a Sunday morning and the surgeon announced that exploration was negative and there was no evidence of abscess. He turned around to wash his gloves before closing the abdomen and the resident who was assisting decided to put his hand in and feel around. He accidentally broke into a huge abscess between the leaves of the coronary ligament at the dome of the liver, and 1,500 cc. of foul smelling E. coli pus were evacuated. The boy had severe peritonitis but recovered and is well today. This abscess had been confined between the leaves of the coronary ligament. It was up so high that biopsy of the lining of the abscess could not be done When there is abscess in that location it can be overlooked even by careful surgeons.

The second case was a woman of 50 who was seen with a diagnosis of liver abscess. Everything pointed to that except that the surgeon did not find the lesion. I was asked to see her. She was having daily chills, fever, and sweats. She had traveled to Florida shortly before, and I thought of malaria. Her physician said he had been in the South Pacific during the war and that he could smell malaria 10 miles away, but we put her on chloroquin anyway. Her temperature came down to normal and we said she was cured. She went home on medication but when she ran out she had trouble again. She then went somewhere else where they reoperated and a huge abscess of the liver was found and evacuated.

A third case was seen at this hospital and was operated upon with a diagnosis of acute gall

bladder disease. An acutely inflamed gall bladder removed but the patient continued a septic downhill course. Postmortem revealed a huge liver abscess replacing the entire right lobe of the liver.

So, the diagnosis often is not settled even on exploratory laparotomy. You must understand that this is possible and be very careful about closing a patient.

I would like now to say a few words about differential diagnosis in the elderly patient with episodes of heart failure. Such a patient may come in with a tender mass in the right upper quadrant and you will think it is a congested liver, except that occasionally it will turn out to be a huge empyema of the gall bladder which must be operated and drained. In one old lady with a tender mass and septic fever it was a huge pyonephrotic mass of the right kidney with stones. A patient with obstruction due to carcinoma of the head of the pancreas may have chills, fever, sweats, high white count, and high alkaline phosphatase for weeks before jaundice appears. We have had two such cases.

You can, therefore, see that this case has everything it should not have if it is a liver abscess, as is often the case.

Dr. Freeark: That was an excellent discussion of the diagnostic possibilities. In many ways this case is typical of hepatic abscess as encountered by the surgeon. You either stumble on it inadvertently or, as in our next case, strongly suspect it, and have difficulty proving it. Dr. Strohl, what about the contributions of the surgeon to this problem?

Dr. E. Lee Strohl: There is little for a surgeon to say after this excellent discussion. I thought this would be a pseudocyst of the pancreas on looking at the roentgenograms and hearing the history. I too would have stubbed my toe. I would not criticize anybody for having done this operation.

What do we do in such a situation? I would not agree with Dr. Cardon about not using a needle. I think a needle, properly used, is a helpful tool in the differential diagnosis of tumor in this particular area. We have done it successfully, but I warn you that it is not advantageous if there are multiple liver abscesses because they usually are small and may not be found with an aspiration needle. We have found that liver abscesses are rather selective as to where they form. The right lobe is eight times more frequently the location than the left. Therefore, in this particular patient I would think a liver abscess on the left side of the abdomen even less likely.

Dr. Diffenbaugh and I have had nine patients with liver abscess that differ slightly from the patients Dr. Cardon has described. The onset of pyogenic liver abscess usually is insidious with several weeks of malaise, fever, and anorexia. Chills and liver pain, however, develop suddenly. Repeated daily chills are uncommon. Chills usually occur for two or three days, then cease, recur at a later date, and are followed by increase in fever and profound malaise. Pain is constant, dull, and located directly over the liver. In the early stages, it may be diffuse over the liver, similar to the liver pain of congestive heart failure. Such pain is supposed to be due to distention of the liver capsule. It becomes localized to one area of inflammatory involvement of the liver capsule at a later date. Some physicians aspirate with a needle at the site of localized tenderness. Pain may not be present at the onset of illness but it is the dominant complaint at the time of hospital admission, which usually is one to three weeks after the onset of the disease.

I would never have made a diagnosis of pyogenic abscess of the liver in the patient presented, but I completely agree on abdominal exploration being indicated. We were taught that exploration was something to be feared; that it was something to be undertaken only if you had not been able to determine the cause of the disease otherwise. But once exploration is attempted and pus encountered, what do you do? You have burned your bridge behind you in that you have free pus in the peritoneal cavity. What to do? I would have done nothing more than insert a good pack and leave the wound open. This is important when you consider what is going to happen in this area. Debris will exude from the wound and there will be evidence of bile drainage. It is important to keep the skin dry and protected or you will have severe irritation. I would pack it widely open and then I would pray, because I think most of these patients do not survive. In our series of nine, seven patients were operated upon and two survived. Prior to the antibiotic era the outcome was even worse. As for multiple abscesses, if you can make the diag-

nosis then just sit tight and load the patient with antibiotic drugs.

Dr. Freeark: The patient was treated in the main as you have suggested. Fortunately he had very little drainage and a benign postoperative course. I might say that, unlike the case Dr. Cardon mentioned, and in true County Hospital fashion, the resident was doing this case and it was he who was washing his gloves when the attending surgeon, Dr. Sam Fogelson, put his hand in the wound and ruptured the abscess. Smear and culture of the drainage were negative for amebas and bacteria. The focus remains unknown.

Case 2.

Dr. William Marshall (Surgical Resident): This 35 year old Negro female entered Cook County Hospital on August 28, 1959, with a four day history of epigastric and right upper quadrant pain associated with repeated emesis. Past history revealed similar previous attacks suggestive of cholecystitis but chills, fever, jaundice, and pruritus were denied.

On admission to the hospital her temperature was 100.8° F., pulse rate 112 per minute, blood pressure 128/85 mm. Hg. The significant physical findings were limited to the abdomen where deep tenderness without rebound tenderness was present in the right upper quadrant. Bowel sounds were active. No masses were palpable.

The white blood cell count was 9,000, hemoglobin 71%. Liver profile was normal except for slightly elevated alkaline phosphatase of 4.6 mg.%.

Conservative management, consisting of Levine suction, broad spectrum antibiotics, and intravenous fluids, brought about gradual subsidence of most symptoms. On September 2, her temperature rose to 101° F. and she developed persistent tachycardia, but without significant increase in abdominal findings. On September 4, the blood pressure dropped to 70/50 mm. Hg. pulse rate was 160 per minute, and temperature 103.6° F. rectally. Bowel sounds became inactive but the abdomen was not rigid and there was no rebound tenderness. The selerae were icteric. Serum amylase was normal and the leucocyte count was 25,000.

The patient was taken to surgery. Under local anesthesia a partial cholecystectomy and proximal cholecystostomy were carried out for acute gangrenous cholecystitis with empyema. The

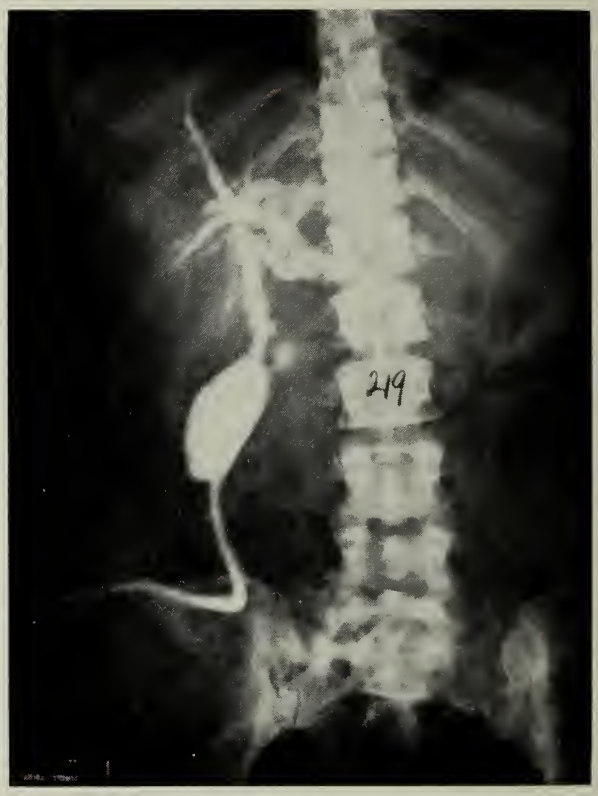


Figure 4

pancreas was normal to palpation, as was the common duct, although lack of abdominal relaxation limited the reliability of these impressions. Following surgery, the patient remained shocky with higher fever, deepening jaundice, and marked lethargy. The biliary tract catheter drained approximately 100 to 300 cc. every 24 hours. The white blood cell count rose to 44,000. NPN to 126, icterus index to 154, and the amylases remained normal. A change of antibiotics brought little improvement in her condition. Culture of the bile returned E. coli, enterococci, and hemolytic Staphylococcus albus coagulase negative.

The cholangiograms are shown here (Fig. 4). Multiple common duct stones had been left behind.

Dr. Freeark: Dr. Strohl and I saw this patient postoperatively but prior to the performance of the cholangiogram. She was in shock. Dr. Strohl made the dogmatic diagnosis of hepatic abscess at this point, while we were thinking more in terms of ascending cholangitis. At any rate, the patient obviously had infection that was not being controlled. We did not know whether there was common duct obstruction.

Dr. Marshall: Her liver at the time of the first

operation was enlarged and mottled but without gross evidence of abscesses.

Dr. Strohl: We would have liked Dr. Cardon's help in this case. I saw her one Saturday morning. We thought she had abscess and ascending infection because she was tender over the entire liver. She was extremely ill and also had the liver abscess facies. Again I thought that prayer was indicated, and I told the residents they must be heroic with their antibiotic drugs. When I suggested the dosage I thought Dr. Marshall would faint. The patient was on 4 gm. parenterally the first day and I suggested that this be doubled. At all events, this patient recovered but some physician still has his work cut out for him. As I look at this cholangiogram, I would not hurry about going back into this patient's abdomen.

Dr. Freeark: On the large doses of antibiotics the patient made a slow but definite recovery. After a cooling off period of several weeks, she was returned to the operating room where Dr. Strohl's diagnosis was confirmed by the finding of residuals of multiple small abscesses on the surface of the liver. The common duct was explored and the remaining common duct stones removed with considerable difficulty. I am happy to report that this procedure was well tolerated.

Dr. Diffenbaugh, is this case similar to those you have encountered in your recent review of this subject?

Dr. Diffenbaugh: In the short remaining time I would like to run through some slides that are representative of the cases we encountered. The first slide is an X-ray of a patient with hepatic abscess and it serves to emphasize the pleural findings on the right side. Rales in this case were marked and confused the clinical picture because the major disease appeared to be intrathoracic. The next slide shows an abscess encountered at this hospital that was cholangitic in origin and one of a number of liver abscesses. The large abscess was drained and the cholangiogram was made by injecting the drainage tract. There were multiple abscesses communicating through the bile ducts.

The next slide illustrates a point Dr. Cardon made of the importance of X-ray study. Here was a tremendous enlargement of the right lobe of the liver, readily noted on a plain film of the abdomen. This can be detected by palpation if the abdomen is not distended or rigid. Otherwise this X-ray may be the first clew to liver enlargement. Hepatic enlargement may appear suddenly and be accompanied by considerable pain.

The last slides are temperature charts of patients with hepatic abscess. As you see, there may not be a daily elevation of temperature. Many days may elapse before a significant rise occurs. McFadzian explains these temperature elevations as due to extension of thrombophlebitis from the area of the abscess They usually are associated with a marked chill. Among our patients we have noted a wide variation in the character of these temperature charts. For example, a patient is shown who recovered after transabdominal drainage of a large pyogenic abscess of the right lobe of the liver. This patient had a sudden septic type of temperature after three weeks of generalized malaise as his only symptom. Also, a child of 12 with marked leucocytosis underwent renal exploration and later thoracic exploration in an attempt to localize an abscess that subsequently was drained on abdominal exploration; the child recovered. You will notice several days during which the temperature remained normal. Just to confuse the issue, I will show this septic type of temperature chart encountered in patients with hepatic necrosis from either primary or secondary carcinoma involving the liver. At the time of autopsy there was no abscess cavity.

Of the nine patients in our series, four were over 60 years of age. Seven of the nine were operated and two recovered. McFadzian of Hong Kong several years ago reported 14 cases of pyogenic abscess of the liver, all of whom recovered. His method of treatment was antibiotic coverage followed by aspiration of the abscess with a needle at the point of greatest liver tenderness. The aspirated pus was replaced by air which prevented the abscess cavity from filling with clots and also served to outline the extent of the abscess on subsequent roentgenograms. If there was not a prompt improvement, contrast media was injected to delineate communicating abscess pockets, requiring more adequate drainage. His method of treatment and its success merit consideration.

Dr. Freeark: Our discussants have certainly done a marvelous job on this difficult subject and we thank them most sincerely.

EDITORIALS

Indications for electroencephalography

When epilepsy is suspected or when there is a possibility of injury to the cerebral hemispheres, an electroencephalogram may yield valuable information. [The electroencephalogram is of little or no practical value for the detection of cerebellar or subtentorial lesions.]

Trauma, infection, vascular disease, and neoplasms commonly produce objective evidence of generalized or localized disorder. The abnormalities that appear are nonspecific for any particular etiology, but the rate at which they develop or subside (as indicated by serial electroencephalograms) may aid in arriving at an etiological diagnosis. For example, decreasing abnormality is negative evidence of tumor but is consistent with a vascular accident.

The location and type of the abnormality indicate what symptoms are to be expected. If seizure-discharges are found they will indicate not only the type of clinical seizure that is likely to occur, but also the medication that has a reasonable chance of preventing the seizures.

Before the advent of electroencephalography, brain injury was thought of as exclusively structural. However, we know now that the brain is an electrochemical organ and that it can be damaged seriously even though its histological structure is not injured. As a matter of fact, when there is histological evidence of damage, the injury is so severe, almost invariably it is associated with destruction of cerebral neurones. Symptoms that develop are deficit symptoms due to loss of a function. Lesser degrees of injury, that are insufficient to kill nerve cells and that do not produce histological changes, may leave cerebral neurones disorganized and functioning abnormally. Such injuries commonly cause a state of hyperirritability, or — to use Hughlings Jackson's term — "a discharging lesion" that tends to express itself in episodic symptoms consisting of exaggerated or abnormal functions. These symptoms correlate with paroxysmal cerebral dysrhythmia, as indicated in the electroencephalogram. It may seem strange, but episodic symptoms of overactivity and underactivity often are more distressing and handicapping than persistent loss of function. Neurosurgeons obtain a therapeutic effect in some cases by converting a nonstructural lesion (for example, an epileptic focus of abnormal electrical discharge) into a structural lesion by removing the disordered brain area.

An illustrative case may help make the foregoing seem less paradoxical and more reasonable. A 40 year old man received a blow on the right temple. It stunned him but did not, so far as he knew, produce unconsciousness. The next day, his only symptoms were headache and dizziness.

Neurological examination five days after the accident was negative. An electroencephalogram, recorded at the same time, showed a localized area of slow-activity in the right midtemporal and right anterior-temporal region (depressive reaction to injury). During the next six months this slow-activity changed gradually to a focus of spike activity (irritative reaction). The patient remained asymptomatic, however. An electroencephalogram recorded six months later revealed an increase in the number and voltage of spike-discharges in the right anterior-temporal region (subclinical epilepsy). One year and two months after the accident the patient began to have daily confusional attacks and trancelike episodes (clinical epilepsy of the phychomotor type). This type of seizure is usual in persons with a spike focus involving the anterior-temporal region.

Certain types of abnormality are seen best in the waking state. But no electroencephalographic study is complete unless it includes also a recording while asleep, because sleep reveals abnormalities and types of disorder that are not evident in the waking state. A form of epilepsy, that has turned out to be the commonest type of epilepsy, shows in the electroencephalogram during light sleep and almost never in the waking state. It is a relatively nonconvulsive form of disorder and is more or less characteristic of adolescence. The diagnostic abnormality consists of 14 and 6 per second positive spikes. These are presumed to come from thalamic or hypothalamic centers that project their activity to the occipital and temporal cortex during light sleep. Although major convulsions may occur in persons with such patterns, the usual symptoms are episodes of dizziness, headache, syncop, paresthesia, pain, loss of emotional control, and episodes of visceral and vegetative disturbances such as sweating, palpitation, nausea, and vomiting. No patients have all these symptoms; usually the attacks consist of only one or two. Such disorder tends to clear up spontaneously in early adult life and usually is rendered asymptomatic with anticonvulsive medication. It has been observed to develop after trauma, as a sequel of acute and subacute encephalitis, and in some cases after supposedly uncomplicated, infectious diseases of childhood. The most common presumptive cause is trauma, next is encephalitis, but in over 50 per cent of cases the cause remains unkown.

An electroencephalogram is an objective bit of evidence; its meaning is as demonstrable as the meaning of a pathological finding in a blood smear. From the correlation of many thousands of electroencephalograms with the clinical findings this meaning has been developed over the last 25 years.

Electroencephalography shows that epilepsy is due to defective voltage production and to improper release of voltage within the brain. A purely clinical definition of epilepsy has become too coarse, arbitrary, and artificial to be useful. The distinction between idiopathic and symptomatic epilepsy no longer has meaning, unless idiopathic is made synonymous with cause unknown. If electroencephalographic evidence of seizure activity is absent (and in electroencephalography as in electrocardiography, clinical disorder may be present and the tracing may be normal) diagnosis must be made on purely clinical grounds. But when the electroencephalogram shows paroxysmal cerebral dysrhythmia of a type known to correlate with a certain type of epilepsy, diagnosis can be made on the basis of the laboratory findings. Usually the clinical and laboratory data are not in conflict. There is an immense amount of concordance. The practicing physician will have no trouble understanding that in some cases, subclinical epilepsy is a necessary and correct diagnosis, just as he has no trouble with the concept of subclinical gall bladder disease. Electroencephalography can show epileptic disorder that is not clinically evident.

The familiarity that comes with use and through communication with a capable electroencephalographer will allow the physician to add electroencephalographic evidence to the clinical findings in some of his problem cases and to increase his understanding. In some cases he may find evidence of serious brain disorder when neurological examination, pneumoencephalography, ventriculography, and arteriography reveal nothing abnormal, and he will be able to help his patient by identifying and treating a nonconvulsive or even subclinical form of epilepsy.

Frederic A. Gibbs, M.D.,
Professor of Neourology,
University of Illinois School
of Medicine.

Ileostomies and ileoptomists

The etiology and pathogenesis of ulcerative colitis remain obscure, even though the disease has been known for more than 100 years. Interest in this challenging problem has grown recently; in part, because of an apparently rising incidence, but more so, because of the continued studies of a small number of physicians, and the inspired activity of a few lay people — persons with ulcerative colitis or their parents, relatives, or friends. This attention, translated into effective clinical and research efforts, eventually should elucidate the nature of the problem and produce more effective therapy. Considerable time will be required.

Until then, numerous patients will require colectomy or ileostomy because of serious complications or failure to respond to adequate medical management. If such individuals lack inadequate information and preparation for the procedure, they often approach surgery with anxiety and fear anticipating chronic invalidism, social exile, or even death. Physicians and surgeons, with occasional exceptions, have failed to appreciate the importance of and the need for careful orientation of patients toward ileostomy and colectomy; requiring them to resort to difficult and at times embarrassing trials and errors. This defect in the management of the surgical colitis patient seems to be the result of at least three factors: insufficient knowledge of the problem by physicians and surgeons, disinterest in these details, and the naive assumption that colectomy automatically relieves the patient of all difficulties.

In recent years this serious void has been filled by the development of ileostomy groups, under the guidance of a few physicians and surgeons, throughout the United States, Canada, Great Britain, Australia, South Africa, and elsewhere in the world. Their objectives in general are impressive:

(1) Physical, emotional, and social rehabilitation of the ileostomy patient through mutual aid, information, and precept;

(2) Improved liaison with the medical profession to increase knowledge and to improve instruction on ileostomy problems;

(3) Education of the public as to the normalcy, competence, and acceptability of ileostomy patients for economic and social opportunities;

(4) Encouraging the interest and efforts of manufacturers to develop more useful ileostomy appliances; and

(5) Participation in appropriate research programs, such as the effects of varying diets upon the composition of the intestinal chyme.

The Chicago ileostomy group, known significantly as Ileoptomists, now has more than 30 members. It is not a postoperative or convalescent club nor a society for the inspection of ileostomies. The president is a roller-skating instructor. Members include a lifeguard, a mechanical engineer who bowls and plays golf, a portrait painter who swims and rides horseback, a registered nurse, a secretary, housewives, and business men. All have returned to active and useful lives. In return, the Ileoptomists are enthusiastically willing to assist ileostomy patients and to provide encouragement and hope for the prospective ileostomy patient. This objective is accomplished surprisingly well in several ways. Most important are the pre- and postoperative visits to the patient by a visiting committee, undertaken only at the request of and authorization by the attending physician and surgeon. These visits, presenting the patient with visual evidence of the full recovery of the ileostomy individual, generate hope, encourage readier acceptance of the operation, and contribute toward a speedier recovery.

Regular meetings are held each month, offering additional opportunity for instruction on the many details of ileostomy care, including appliances, the control of odors, care of the skin around the ileostomy, and diet. The scientific programs of the Ileoptomists thus far have included such topics as: What is an Ileostomy? The Nature of Ulcerative Colitis, Skin Care of an Ileostomy, and the Procedure of Visiting Prospective Ileostomy Patients. Ileoptomists have addressed several nurses groups and, as individuals, have endeavored to acquaint professional and lay people with the remarkable rehabilitation to be expected in most cases. In addition, the Ileoptomists publish a monthly bulletin containing news items, humor, and information on ileostomies and appliances. All these activities are undertaken cheerfully, and inspirationally, without any charges or fees. The financial needs of the Ileoptomists are ap-

proached, and not usually met, by the assessment of dues and by rare modest donations. The accomplishments of this group have been considerable, in the short period of its existence and despite limited resources. An increasingly important role for them is to be anticipated as their usefulness becomes better known.

One of the rewarding experiences of the physician is to contribute to and observe the complete restoration of the incapacitated and the sick to useful, happier lives. I can think of no more appropriate tribute to the Ileoptomists than the following quotation from an anonymous source:

"Sick people ask their God, 'Why must I suffer?' Possibly the answer is in the work of the potter. Fine ceramic pieces are not made by setting clay out in the sun. They come only from the white heat of the kiln. In the firing process some pieces are broken, but those that survive the heat are transformed from dull clay into objects of priceless beauty. And so it is with the sick, suffering, and crippled people. Those who survive their illness or overcome their handicaps, through medical skill, opportunity, work, and courage, take their places back in the world with a depth of spirit which we can hardly measure."

Joseph B. Kirsner, M.D., Ph.D.,
Professor of Medicine,
University of Chicago.

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Good luck Mr. President

I doubt if our new crop of presidential aspirants will be discouraged by the tradition that presidents elected at 20 year intervals die in office. According to Wold[1] these presidents and the years in which they were elected are:

William Henry Harrison, 1840; Abraham Lincoln, 1860; James A. Garfield, 1880; William McKinley, 1900; Warren G. Harding, 1920; and Franklin D. Roosevelt, 1940. By a peculiar twist of fate this tradition would still have carried on had Wendell Willkie been elected in 1940.

[1]Karl C. Wold, M.D. Mr. President — How is Your Health? St. Paul and Minneapolis, Bruce Publishing Co., 1948, p. 204.

DUES

Many members missed reading about the action of the House of Delegates of the ISMS last May, at which time it was voted to increase the dues $10 per year. This is the first increase since 1950 (except for the $20 A.M.E.F. assessment in 1953).

A breakdown of the $50 now paid by members is as follows:

To the A.M.E.F.	**$20.00**	
To the Benevolence Fund	**2.00**	
Balance for ISMS		**$28.00**

This is little more than $2.00 per month per member to run a large state medical society and is less than many similar societies in other states.

The question has arisen as to why the State Society cannot get along on the $1.50 per month per member previously charged. The answer would seem to be relatively simple in this era of rising costs. In addition, the society is undergoing a complete reorganization, following a survey by Rogers, Slade & Hill. Briefly, as a result of this survey, the Monmouth and Chicago offices are being consolidated with a branch office at Springfield, the public relations department is being enlarged, badly needed office equipment is being purchased, and the society's activities in both the scientific and socioeconomic fields are being expanded. These changes are badly needed and will enable your society to give you better service in the future.

So you think you have trouble?

The government is up to its ears in medical controversy and our legislators, cabinet secretaries, and committees may be tempted to believe the loudest vocalizers. Food faddists and cancerophobists are vying with representatives of the food and drug industries and levelheaded scientists in trying to reach conclusions on important issues. The main problem revolves around the Delaney cancer clause in the food additive legislation.

It must have been embarrassing for the Department of Health, Education, and Welfare to read of conflicts of opinion in their own department. Surgeon General Leroy E. Burney, of the U.S. Public Health Service blamed smoking as the principle cause of lung cancer; his article in the J.A.M.A. contained 81 citations from leading studies here and abroad.[1] Meanwhile Dr. Wilhelm C. Hueber, of the National Cancer Institute, told the American Association for the Advancement of Science that smog is the main culprit. He says small amounts of carcinogenic agents are found in cigarette smoke but does not consider smoking the chief etiologic agent in carcinoma of the lung. Then, Secretary Flemming was seen on TV defending his position on cranberries. School children began asking him why he banned cranberries but allowed smoking. It could happen only in America.

Robert B. Marin, M.D. may have the solution when he said, "With air pollution and cigarette smoking both possible causes of cancer, the public is understandably confused. Whether to stop smoking or stop breathing leaves little alternative. In the meantime, we can only hope that the aroma of civilization will improve. Conceivably, smog could be combustible and eliminate us all in one gloriously pungent puff."[2]

1. Burney, Leroy E.: Smoking and Lung Cancer, J.A.M.A. Nov. 28, 1959.
2. Marin, Robert B.: What's in the Air? J.M. Soc. New Jersey Oct. 1959.

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Great steps in human progress are made by things that don't work the way philosophy thought they should. If things always worked the way they should, you could write the history of the world from now on. But they don't, and it is those deviations from the normal that make human progress. —*Charles F. Kettering*

Literary gems

Shakespeare — poet — actor — playwright as he was — knew so much about so many fields he could have been a lawyer, printer, minister, astronomer, or angler; he could have been a physician too, according to Dr. Sam C. Cowan, Sr.

After an exhaustive study of medical references in Shakespeare's works, Dr. Cowan found 37 pertained to drugs and herbs. In addition, the bard's references to Hippocrates, Aesculapius, Paracelsus, and Galen, showed he was familiar with the history of medicine.

Among the gems selected by Cowan are:

"Sickness is catching."

Midsummer Night's Dream 1-1

"But I consider by medicine
Life may be prolonged, yet
Death will seize the doctor, too."

Cymbeline 5-5

Several references are made to epilepsy, particularly the Jacksonian type. It also is called the falling sickness. Iago, after making insinuations to Othello about Desdemona, says:

"My Lord is fallen into an epilepsy:
This is his second fit; he had one yesterday."

Cassio:

"Rub him about the temples."

Iago:

"No, forbear;
The lethargy must have his quiet course:
If not, he foams at mouth, and by and by
Breaks out to savage madness."

Othello 4-1

Shakespeare had some idea on hygiene, sanitation, and quarantine as public health measures. Coriolanus, speaking of citizens, says:

"Bid them wash their faces
And keep their teeth clean."

The porter in Macbeth, according to Cowan, must have been a hard steady drinker and probably more ale than sack. He says that drink is a great provoker of three things —

"Nose painting, sleep and urine.
Lechery it provokes and unprovokes.
It provokes the desire, but unprovokes the performance;
Therefore, much drink may be said to be an equivocator with lechery."

Macbeth 2-3

Roland R. Cross, M.D.
1888-1959

Health officer extraordinary, Dr. Roland R. Cross was a man who radiated a warm friendly spirit and inspired good will and confidence among all with whom he came in contact. During his 19 year tenure as director of the Illinois Public Health department, he earned state-wide popularity which revealed itself particularly among the medical profession, members of the General Assembly, and state government personnel generally. When bills of public health or medical implications were pending in the legislature, a frequently heard question at committee hearings was, "What does Dr. Cross think of this?" His endorsement carried much weight with legislators at Springfield.

Honest almost to a fault, the management of the far-reaching and complex financial affairs of the state department of public health to avoid even the suspicion of evil-doing was almost a passion with him. He shuddered at the very thought of scandal in the department. He took exceptional pride in the fact that negotiations involving millions of dollars were handled by the department during his tenure without the development of even a minor scandal.

Devotion to duty, to his profession, and to his family were cardinal principles in his life. He was a man of great compassion and the door to his office was always open to anyone who wished to see him. Nothing gave him more genuine pleasure than to respond with his superb professional art to the rather frequent calls for emergency medical help in the state house, moving quickly with his little black bag. Reviving a prostrate person was not an unfamiliar experience with him. His well developed sense of humor guided him instinctively to where good stories were told and enjoyed and he loved to recall bucolic pranks of his rural childhood and youth.

Born at Dahlgren, Illinois, July 7, 1888, Dr. Cross died in Memorial Hospital in Springfield, November 28, 1959, aged 71. Between those two vital dates, he acquired a medical degree from the American Medical College of St. Louis; took graduate training in medicine at Washington University and at Mayo Clinic; spent five years in medical work among Indians for the federal government; served as a medical officer with the 90th Division of the U. S. Army during World War I; practiced medicine at Dahlgren after the termination of the war until 1933 when he accepted the position of district health superintendent of the Illinois Department of Public Health. On January 16, 1940 he was appointed by Governor Henry Horner to the position of Assistant Director and on October 19th of the same year, Governor John Stelle appointed him director of the Illinois Department of Public Health. Thereafter, he was reappointed to that position by Governors Dwight Green, Adlai Stevenson, and William G. Stratton.

Many new functions and activities evolved in this department during his tenure. The volume of growth and expansion is suggested by the appropriations to the department from the state's general revenue fund, which were approximately $16 million greater for the last than for the first biennial budget during Dr. Cross' tenure. In addition, federal funds in excess of $10 million for the current biennium are administered by the department.

Dr. Cross was chairman of the State Sanitary Water Board, the Hospital Advisory Council, and the committee on civil defense of the Conference of State and Territorial Health Officers. He was also a member of the American Legion, Post 32, DAV Hall-Hagler Chapter No. 15, American Medical Association, Illinois State Medical Society, American Public Health Association, and the First Christian Church of Springfield.

He is survived by his wife, Isabel H., four sons, eight grandchildren, one brother, and one sister.

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Hospital plus medical-surgical coverage for senior citizens available by Rockford Blue Cross-Blue Shield plans

The Blue Cross Plan, Illinois Hospital Service, Inc., Rockford, has announced a new special nongroup senior citizen's hospital program for protecting the elderly against the cost of hospital care. According to Mr. Kenneth K. Clark, executive director, this new certificate will provide hospital care benefits in conjunction with medical-surgical benefits now available by the companion plan, Blue Shield, Medical-Surgical Service of Illinois, Rockford.

The Rockford Blue Cross-Blue Shield Plans serve 92 counties in Illinois that have developed an active senior citizen's nongroup hospital-medical-surgical health program without a limited age requirement. The plan is for people 60 years of age or over who heretofore were unable to enroll with Blue Cross-Blue Shield on an individual, nongroup basis.

The cost of the Blue Cross-Blue Shield Senior program is $6.28 monthly or $18.80 quarterly, each person. The rates are uniform for both sexes. Benefits under the hospital care certificate include 30 days of hospital care per year with room allowance of $10.00 per day. Additional benefits are outpatient hospital benefits for accident cases and minor surgery, operating room and emergency room, surgical dressings, casts, splints and medical supplies, laboratory tests, drugs, medicines, and intravenous solutions, and one-half the cost of oxygen therapy and the administration of blood. Benefits are available in any general hospital anywhere, and individual membership will not be canceled for excess usage or because of age. Pre-existing conditions are covered after a 6 month waiting period.

Benefits under the medical-surgical care certificate include liberal surgical benefits for procedures in the hospital, in the physician's office or clinic, in-hospital medical visits (120 days per contract year), X-ray examinations at the hospital or the physician's office, radiation therapy and radioactive isotopes, surgical assistants, intensive medical care, and the administration of anesthetics.

Rockford Blue Cross-Blue Shield traditionally has and will continue with the same policy they had in the past. There is no age limit on group enrollment, and continuation of Blue Cross-Blue Shield coverage is permited to all members who have acquired it prior to reaching age 65.

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There are one-story intellects, two-story intellects, and three-story intellects with skylights. All fact collectors, who have no aim beyond their facts, are one-story men. Two-story men compare, reason, generalize, using the labors of fact collectors as well as their own. Three-story men idealize, imagine, predict; their best illumination comes from above, through the skylight.

—Oliver Wendell Holmes

Editorials from other journals

Cranberry Smash

The recent hullabaloo about cranberries was initiated on 9 November —"Black Monday" to the cranberry industry—when Secretary of Health, Education, and Welfare Arthur S. Flemming warned the public that a part of the current crop was contaminated by a weed killer, aminotriazole. The announcement raised the curtain on a political drama that is variously interpreted according to the predilections or interests of the observers. One version has it that the action was an unwarranted attack by Big Government on a small industry that supplies the American housewife with a "pure, wholesome, and nutritious food." At the opposite extreme, the Secretary is pictured as a champion of public health, protecting the consumer in courageous disregard of the political consequences.

Whatever the interpretation, the surface facts are not in dispute. The product, aminotriazole, is properly registered with the Department of Agriculture as an economic poison. If it is used in cranberry bogs as directed, within a few days after harvest, and at no other time, it will not be incorporated into the berries produced the following year. But if it is used during the growing season it will be incorporated into the berries.

In 1957 the product apparently was misused by some growers, and the FDA succeeded in having 3½ million pounds of cranberries withdrawn from the market on the grounds that the berries had not been shown to be safe for human consumption. Before that, the American Cyanamid Company had asked that a tolerance for a certain amount (reportedly 1 part per million) of aminotriazole be set, but the FDA denied the petition on the grounds that tests run for the company by an independent laboratory showed the compound to be a possible carcinogen (cancer inducer). In 1958 the company again petitioned that a tolerance be set, and the petition was again denied; no appeal was made.

Apparently few growers misused the product in 1958, and no seizures were made. In 1959, however, contaminated berries were found, first in Washington and Oregon and then in Wisconsin. Impounded lots are being tested and released as soon as they are shown to be uncontaminated.

What are the scientific issues? This question would be easier to discuss, if not to answer, if the basic facts about the compound had been made public by the FDA. As of this writing, both the petition and the scientific appraisal by FDA scientists and physicians are confidential, but it has been possible to obtain some information. The tests showed that rats fed for 2 years on a diet containing 100 parts per million of aminotriazole developed a significant number of thyroid adenomas and adenocarcinomas (cancers); those similarly fed at the rate of 50 parts per million developed adenomas (nonmalignant tumors) but not, according to a company spokesman, adenocarcinomas. It is a reasonable inference that the FDA disagreed with this interpretation of the results as well as with the company's contention that the one rat out of a total of 10 that developed an adenoma at a feeding level of 10 parts per million was not statistically significant. The company argues that the substance is not a carcinogen; it must be administered continuously over a long period of time to induce cancer; a single dose, no matter how large, is not effective.

Secretary Flemming disagrees and bases his action on the statement in the Federal Food, Drug, and Cosmetic Act which says that "no additive shall be deemed safe if it is found to induce cancer when ingested by man or animal."

The scientific issues are unresolved. Whether the Secretary's position is extreme cannot be appraised until the evidence is out and expert opinion is brought to bear. One prediction is safe: some battle lines have been drawn for the next session of Congress.—*G. DuS., Science, Nov. 26, 1959.*

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Ulcer and Type O

The role of heredity in the etiology and pathogenesis of duodenal ulcer has been postulated, and attempts have been made to show the relationship of ulcer to ABO blood groups. Not all investigators are in accord. On the assumption that 85 per cent of the population either is type O or type A, Buckwalter et al. present convincing evidence of statistically significant increases of type O with concomitant decreases in the three other blood types and that this same relationship held for hyperchlorhydria. This corroborated the British claim that persons with type O are 35 per cent more likely to develop peptic ulceration than are other blood types. Duodenal ulcer has been described in families, but a true ulcer personality has never been universally accepted. *C. Joseph DeLor, M.D. and Floyd Beman, M.D. Duodenal Ulcer: Some Observations on Pathogenesis. Ohio M.J. Oct. 1959.*

MEDICAL ECONOMICS



Nursing Education

PHYSICIANS are aware of the great need for additional nurses. The demand far exceeds the present supply, hence any program that will help meet this demand is of vital interest to the medical profession. The new nursing program at Northern Illinois University of DeKalb provoked the following correspondence:

Doctor Annette Lefkowitz
Director, School of Nursing
Northern Illinois University
DeKalb, Illinois

Dear Doctor Lefkowitz:

The Medical Economics Committee of the Illinois State Medical Society tries to keep the Society informed regarding many subjects that are presenting new aspects in the practice of medicine. One of the things that concerns us all very much is the shortage of nurses. Naturally, anything designed to help alleviate that shortage is welcome.

At the recent meeting of the Committee it was felt that an article could be published in the Illinois Medical Journal dealing with the new school you are setting up. It would be proposed that the format of the article would be in the nature of an exchange of letters between us. I wonder if you would be so kind as to write me a letter we could publish decribing your program?

It is my understanding that the students will be at DeKalb for their first year. Thus, a student and the school together would be financing the cost of the first year's work. This would reduce the cost of maintaining instructors in didactic work which the hopsital program would entail. How much do you think the hospital would save by not having to pay for the expenses of the first year's work? Do you think it would reduce the cost of maintaining the nursing school by 40 per cent? It is my understanding also that you will have a group of affiliated hospitals where students will spend their second and third years, after which they would receive their R. N. Degree. If they should come back to DeKalb for their fourth year, would the bachelor or science degree they received by the standard bachelor of science degree in nursing education which is so highly recommended? How many hospitals do you envision as being part of your affiliated program? Within what geographical distance will you consider approving a hospital for affiliation? What criteria would a hospital have to meet to satisfy affiliation recommendations? Would your department have periodical or continuous inspection of the program of such an affiliated hospital? Would the students be required to live at the affiliated hospital?

How large a program do you plan to establish? Or would it be like an open end trust — it would simply grow and enlarge as long as students are available? Is the pattern you are establishing at DeKalb similar or even intergrated with a similar program at the other normal universities and colleges?

I hope you can see from the questions I have asked the trend of my thinking and what I feel

would be an informative article for the journal. Any other pertinent information you would like to include would be welcome.

Sincerely,

(Signed)

Roland R. Cross, Jr., M.D.
Chairman
Medieal Eeonomics Committee, ISMS

The following reply was reeeived from Doctor Lefkowitz:

December, 1959

Dr. Roland R. Cross, Jr.
Chairman, Medieal Economies Committee
Illinois State Medical Soeiety
952 North Michigan Avenue
Chicago 11, Illinois

Dear Doctor Cross:

Thank you so much for your letter and the questions pertaining to the new nursing program at Northern Illinois University. We recognize the importance of having the medieal profession well informed as to our objectives, and appreciate your interest.

I would think it important that we, in the medical and nursing professions, dwell on the notion that the new program will add to the number of nursing praetitioners, and will provide nurses of a ealiber to inhanee the work of the medical team.

One of the principle objeetives of the new type program is the preparation of practitioners with the needs of patients, of the present and the future, being kept in mind. We are all aware that the changes in medical eare have resulted in different demands upon the nurse. The general tendency of our society to undergo hospitalization for diagnostic purposes, as well as acute medieal and surgical disorders, has uneovered the need for nurses who are skilled in the applieation of mental health prineiples as well as technical skills. It is our expeetation the eollegiate registered nurse will be much more effeetive in the new seheme of things. Registered nurses whose basie orientation ineludes an understanding of soeial and cultural faetors, would be able to cope with the problems and the eare of patients with ease.

The plans for the program at Northern are based on the assumption that the student attending the university pays for the cost of the total program through all four academic years. This includes the same eosts borne by all other students in attendance at this state supported university. The cost of uniforms also is paid for by students.

The size of the program will not be restricted because of limitations of laboratory facilities. Many responsible institutions have signified an interest in co-operating with the nursing program of the university. Therefore, our growth can be unrestrieted from this point of view.

It is the responsibility of the university to employ qualified faculty to plan, teach, and supervise the education of students who enroll. This includes a eomplete faeulty for the School of Nursing of the university. This faculty will include personnel teehnieally competent to work and teach effectively in the hospital situation. The major responsibilities of the nursing faculty of the university will be of an instructional and supervisory nature. They will accompany all students to all hospital and related laboratory experiences. This policy of collegiate education removes completely from the hospital any financial obligations for the students' education during all four years.

These statements pertaining to financing nursing education are related only to programs stated to be the responsibility of the university. In a program sponsored by the university, the co-operating institutions (hospital, publie health ageney, etc.) have no finaneial responsibility for the education of the student per se. It is expected that the co-operating institution would have finaneial responsibility relative only to in-service educational programs on all levels for their permanent personnel.

You mentioned in your letter a possible 40 per eent reduetion in the cost of maintaining schools of nursing by having a eo-operative agreement with a university. This, I presume, related to the cost to schools whieh are diploma in nature and are run by hospitals, as there is no eost to the hospital in terms of our particular type of program. In diploma programs for which the hospital has assumed the total financial responsibility for the education of students, the use of a co-operating degree granting institution to teach basie courses would not reduce appreciably the cost to the hospital; since the cost of employing well qualified personnel has increased tremendously and the standards for facilities in diploma sehools also have increased, the savings would have to be utilized in faculty salaries.

The program planned at Northern Illinois University requires the presence of the nursing student on the university campus for all four years during which the program is offered. At no time do students of Northern affiliate in the sense that one customarily associates the idea of an affiliating student. Northern Illinois University will have agreements with hospitals and other agencies that will permit nursing students and their faculty to use the facilities of the institution for laboratory purposes. Students will not be permitted at the co-operating laboratory institution without university faculty in attendance.

University nursing students start in their first year with an orientation to hospital administration and economics, with opportunities provided for observation in public and private institutions and public health agencies. This is to encourage the development of insights into the magnitude of hospital mechanics involved in providing care for the sick. This also encourages a wholesome respect for the various personnel responsible for the management and services offered by these institutions. With this background the students are taught in the hospital the basic technical skills necessary for functioning as a nurse. By the end of the second year, the students will have learned many of the basic nursing skills. They will be prepared to enter the upper division of the university where they will incorporate the basic principles of psychology, sociology, anthropology, and the basic sciences. At the end of four years the student will be graduated from the university with a Bachelor of Science degree with a major in nursing. They also will be eligible to take the state board examination to become licensed to practice as a professional nurse in the State of Illinois. The program at Northern has no cut-off point after the third year. A student is required to complete work for the degree in order to be graduated.

With the present enrollment of 21 students in the freshmen class, Northern will utilize the facilities of two approved hospitals within a one hour drive from the campus. Faculty and students are transported by University buses to each laboratory class. Four to six hours per week are devoted to instruction and supervise patient care, starting in the first year. As the student progresses into the more complex areas of patient care, the total number of laboratory hours is increased. By the fourth year the student will be spending approximately three-fourths of her time in laboratory experiences in the hospital and other health agencies.

The criteria applied in the selection of a co-operating institution to be used for a laboratory include: interest on the part of the institution in co-operating with the university; distance factor precludes any institution beyond an hour to one and one-half hours travel time from the university; co-operating institution must have been approved by the proper accreditating agencies; evidence of the presence of an active on-going in-service educational program for permanent personnel; adequacy of facilities; and high level patient care.

The pattern of the program at Northern has been used with variations by other colleges and universities, but this is a pioneering venture in Illinois. None of the private or state universities in Illinois is using this particular program design. I was responsible for the establishment of a similar program in the Pacific northwest and now number among my professional colleagues many of my former students. These people are gainfully employed as professional nurses in hospitals, public health agencies, public schools, and universities. Since the educational climate in Illinois appears propitious, we are anticipating great things from the graduates of our program at Northern.

I trust this information will provide you with the answers to some of your questions about "Nursing at Northern." I am also enclosing a brochure which elaborates some of the details covered in the letter. If you would like further clarification on any of this material, please contact me again.

Thank you for your interest.

Sincerely yours,

(signed)

Annette S. Lefkowitz, R.N., Ed. D.
Director, School of Nursing
Professor of Nursing Education

Doctor Lefkowitz enclosed a brochure, as mentioned above, describing the new School of Nursing whose first class was enrolled in September, 1959. Summary of this brochure elicits the following information:

The students enrolled under this program will

have a background stressing general education, to form a basis on which to build a professional program. The student will live at the university and participate in the activities there in the same manner as any other student. A graduate of this program will be prepared for a dual roll as professional practitioner of nursing and as a fully participating, active citizen of the community to which she belongs. Advanced preparation for school nursing, public health nursing, and teaching in schools of nursing will be more easily acquired building on this basic program.

The specific training in nursing, as compared to the general education program, will be obtained away from the university, so planned that the student will not be taken away from the campus for any extended period. The entire faculty will be employed by the University accompany the student as she receives hospital laboratory experiences away from the campus. The university will transport the students and their instructors to the selected laboratories by means of school buses. During this period of transit, the instructor will be prepared to discuss the experiences anticipated and upon their arrival. Thus, the bus trip will constitute a class on wheels. Clinics, hospitals, and public health facilities within a subscribed radius of the university will be used as laboratories.

Students to be admitted to the school of nursing will be on the same basis as other students and will be expected to have similar sound high school preparatory background. They will live in the dormitory or in nearby boarding homes approved by the university or, if close enough, at their own homes. The nursing student must plan on spending the same amount of money as it would take for a general college course. After receiving a Bachelor of Science degree with a major in nursing, the student will be eligible to take the state license examination for her R.N. degree.

Additional information pertinent to the program may be received by writing to the Director of Nursing Education, Northern Illinois, DeKalb, Illinois.

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Pinworms and the appendix

In the Mid-Hudson Valley region of New York State, the incidence of Enterobius vermicularis infection was 13 per cent of 100 consecutively examined, surgically removed appendices. The tendency for these infections to occur more frequently in normal than in pathologic appendices would seem to make the significance of this parasite in the pathogenesis of acute appendicitis questionable. *David S. Gerbarg, M.D. and Herbert Derman, M.D. Incidence of Appendiceal Pinworms in the Population of the Mid-Hudson Valley. New York J. Med. Dec.* 15, 1959.

CORRESPONDENCE



First Illinois cancer conference to be held

The First Illinois Cancer Congress will be held in Springfield, March 9-11. It will be sponsored by the Illinois Department of Public Health in co-operation with the Illinois State Medical Society, the Illinois Academy of General Practice, and the Illinois Division of the American Cancer Society.

Stress will be placed on the early detection of cancer. Physicians who are members of the AAGP will receive category II (informal) credit for attendance.

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American College of Surgeons to hold regional meeting

The American College of Surgeons will hold a sectional meeting in Minneapolis, April 11-13, and in Rochester, Minn., April 14.

An extensive series of hospital programs will be presented in addition to sessions in hotels. Among the subjects to be covered will be surgical treatment of regional ileitis, graft coverage of deep burns, operations for peptic ulcer, surgical diseases of the spleen, management of acute renal failure and various type of trauma, and prophylactic and adjuvant treatment of different types of cancer.

Dr. Clinton L. Compere, Chicago, will moderate a panel on postoperative management of problem amputees. The collaborators will be Drs. Fred E. Vultee, J. Warren Perry, and Herbert B. Hanger, Chicago. Dr. Warren H. Cole, Chicago, will be the moderator of a panel on gastrointestinal bleeding.

For further information, write to the ACS, 40 East Erie Street, Chicago 11.

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Clinics for crippled children listed for March

Twenty-three clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing service. There will be two special clinics each for children with cardiac conditions or cerebral palsy condition, and one for children with rheumatic fever. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

March 2 — Carmi, Carmi Township Hospital
March 2 — Hinsdale, Hinsdale Sanitarium
March 2 — Rock Island (Cerebral Palsy), Foss Home, 3808 8th Avenue

March 3 — Effingham, St. Anthony Hospital
March 4 — Chicago Heights (Cardiac), St. James Hospital
March 8 — East St. Louis, St. Mary's Hospital
March 8 — Peoria, Children's Hospital
March 9 — Champaign-Urbana, McKinley Hospital
March 9 — Joliet, Silver Cross Hospital
March 10 — Springfield, St. John's Hospital
March 10 — Sterling, Community General Hospital
March 15 — Alton, Alton Memorial Hospital
March 16 — Evergreen Park, Little Company of Mary Hospital
March 16 — Jacksonville, Passavant Hospital
March 17 — Elmhurst (Cardiac), Memorial Hospital of DuPage County
March 17 — Rockford, St. Anthony's Hospital
March 17 — Sparta, Sparta Community Hospital
March 22 — Peoria, Children's Hospital
March 23 — Springfield p.m. (Cerebral Palsy), Memorial Hospital
March 23 — Aurora, Copley Memorial Hospital
March 24 — Decatur, Decatur-Macon County Hospital
March 29 — Effingham (Rheumatic Fever), St. Anthony Hospital
March 30 — Centralia, St. Mary's Hospital

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The Chicago Medical Society's Annual Clinical Conference

March 1-4, 1960—Palmer House, Chicago

PROGRAM

Tuesday, March 1

8:30 a.m. "Some Observations on the Localizing Patterns of Arteriosclerosis"
Dr. Michael E. DeBakey, Professor, Department of Surgery, Baylor University College of Medicine, Houston, Texas

9:00 a.m. "Complications of Peptic Ulcer"
Dr. Joseph B. Kirsner, Professor of Medicine, University of Chicago School of Medicine, Chicago

9:30 a.m. "Modern Concepts of Malignancy of the Thyroid"
Dr. John Beach Hazard, Chairman, Division of Pathology, Cleveland Clinic Foundation, Cleveland, Ohio

11:00 a.m. "Pharmacological Depression in the Course of Essential Hypertension"
Dr. John I. Nurnberger, Professor and Chairman, Department of Psychiatry; Director of the Institute of Psychiatric Research, Indiana University Medical Center, Indianapolis, Indiana

11:30 a.m. "Recognition and Management of Hearing Loss"
Dr. Howard P. House, Clinical Professor and Chairman, Department of Otolaryngology, University of Southern California School of Medicine, Los Angeles, California

12:00-1:30 p.m. Luncheon

1:30 p.m. "What Has Been Learned from Renal Biopsy"
Dr. Robert M. Kark, Professor of Medicine, University of Illinois College of Medicine; Attending Physician, Presbyterian-St. Luke's, Research and Educational, and Cook County Hospitals, Chicago

2:00 p.m. "Diagnosis and Surgical Management of Kidney Disease"
Dr. Eugene F. Poutasse, Assistant Professor of Urology, Frank E. Bunts Institute, Cleveland, Ohio

2:30 p.m. "Inflammatory Disease of the Intestine"
Dr. Thomas E. Machella, Chief, Gastrointestinal Section of the Medical Clinic of the Hospital of the University of Pennsylvania; Associate Professor of Medicine, School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania

4:00 p.m. "Office Management of Certain Anorectal Lesions"
Dr. Raymond J. Jackson, Associate Professor in Proctology, Mayo Foundation, University of Minnesota; Chief, Department of Proctology, Mayo Clinic, Rochester, Minnesota

4:30-5:30 p.m. Clinicopathologic Conference
Dr. John Beach Hazard, Cleveland, Ohio—Moderator

Wednesday, March 2

8:30 a.m. "Choice of Operations on Peptic Ulcer"
Dr. Robert J. Coffey, Professor of Surgery, Director of the Department of Surgery, Georgetown School of Medicine, Washington, D.C.

9:00 a.m. "Pyelonephritis"
Dr. Edward H. Kass, Associate Professor of Bacteriology and Immunology, Harvard Medical School; Associate Physician, Thorndike Memorial Laboratory; Associate Director, Mallory Institute of Pathology, Boston City Hospital, Boston, Massachusetts

9:30 a.m. "Dissolution of Clots by Intravenous Therapy" Dr. Sol Sherry, Professor of Medicine, Washington University School of Medicine, St. Louis, Missouri

11:00 a.m. "The Use of Progestational Agents in the Treatment of Functional Uterine Bleeding"
Dr. Willard M. Allen, Professor of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, Missouri

11:30 a.m. "Psychosomatic Aspects of General Medical Disorders"
Dr. Thomas H. Holmes, Professor of Psychiatry, University of Washington School of Medicine, Seattle, Washington

12:00-1:30 p.m. Luncheon

1:30 p.m. "Management of Metastatic Tumors of the Lung"

Dr. F. H. Ellis, Assistant Professor of Surgery, Mayo Foundation Graduate School, University of Minnesota; Head of Section, Division of Surgery, Mayo Clinic, Rochester, Minnesota

2:00 p.m. "Relation of Salt to Hypertension"
Dr. John M. Weller, Associate Professor of Internal Medicine, The University of Michigan Medical School, Ann Arbor, Michigan

2:30 p.m. "Secondary Malabsorption Syndrome: Diagnosis and Management"
Dr. William G. Sauer, Consultant in Medicine, Mayo Clinic; Assistant Professor of Medicine, Mayo Foundation Graduate School, Rochester, Minnesota

4:00-5:00 p.m. Panel Discussion—"Control of Spread of Cancer"
Dr. Warren H. Cole, Chicago, Moderator
Dr. John Beach Hazard, Cleveland, Ohio
Dr. Stuart S. Roberts, Chicago

Fellowship Hour—6:00 p.m.
Dinner—7:00 p.m. (Informal)
Grand Ballroom
Entertainment—Dancing
Tickets available at Registration Desk

Thursday, March 3

8:30 a.m. "The Diagnosis and Management of Intraepithelial Cervical Cancer"
Dr. William F. Mengert, Professor and Head, Department of Obstetrics and Gynecology, University of Illinois College of Medicine, Chicago

9:00 a.m. "The Clinical and Laboratory Recognition of Drug-Induced Hemolytic Anemias"
Dr. William H. Zinkham, Assistant Professor of Pediatrics, Johns Hopkins University School of Medicine, Baltimore, Maryland

9:30 a.m. "Management of Heart Failure"
Dr. L. Feldman, Associate Professor of Medicine, University of Illinois College of Medicine; Attending Physician, Cook County, Mount Sinai, and Columbus Hospitals, Chicago

11:00 a.m. "Oral Agents in the Treatment of Diabetes"
Dr. Leo P. Krall, Senior Staff, Joslin Clinic and New England Deaconess Hospitals; Consultant (Diabetes), Boston Lying-in Hospital, U. S. Public Health Service, Danvers State Hospital, Boston, Massachusetts

11:30 a.m. "Hypogammaglobulinemia"
Dr. Horace H. Zinneman, Associate Professor, Department of Medicine, University of Minnesota Medical School, Minneapolis, Minnesota

12:00-1:30 p.m. Luncheon

1:30 p.m. "Fluid and Electrolyte Problems"
Dr. Peter J. Talso, Professor of Medicine, Stritch School of Medicine of Loyola University, Chicago

2:00 p.m. "Physiologic Considerations in the Treatment of Graves' Disease"
Dr. Rulon W. Rawson, Chief, Department of Medicine, Memorial Hospital; Chief, Division of Clinical Investigation, Sloan-Kettering Institute; Professor of Medicine, Cornell University Medical College, New York, New York

2:30 p.m. "Diagnosis of Anemias"
Dr. Clement A. Finch, Professor, Department of Medicine, University of Washington School of Medicine, Seattle, Washington

4:00-5:00 p.m. Panel Discussion—Reactions to Drugs
Dr. Mark H. Lepper, Chicago,—Moderator
Dr. William H. Zinkham, Baltimore, Maryland
Dr. Samuel M. Feinberg, Chicago
Dr. Hyman J. Zimmerman, Chicago
Dr. George H. Berryman, Chicago

Friday, March 4

8:30 a.m. "Intestinal Obstruction in the Newborn"
Dr. H. William Clatworthy, Jr., Associate Professor of Pediatric Surgery, Ohio State University Medical School; Chief, Department of Pediatric Surgery Columbus Children's Hospital, Columbus, Ohio

9:00 a.m. "Pitfalls in Pediatric Anesthesia"
Dr. M. Digby Leigh, Associate Professor of Surgery (Anesthesia), University of Southern California; Chief of Anesthesiology, Children's Hospital of Los Angeles, Los Angeles, California

9:30 a.m. "Pancreatitis"
Dr. Richard H. Egdahl, Assistant Professor of Surgery, Director, Surgical Research Laboratories, Medical College of Virginia, Hospital Division, Richmond, Virginia

11:00 a.m. "Airspace Disorders of the Lung"
Dr. Edward A. Gaensler, Associate Visiting Surgeon (Thoracic) and Director, Pulmonary Division, Thorndike Memorial Laboratory, Boston City Hospital; Clinical Associate in Surgery, Harvard Medical School; Instructor in Surgery, Boston University School of Medicine, and Senior Instructor in Medicine, Tufts University School of Medicine, Boston, Massachusetts

11:30 a.m. "The Child Who Will Not Go To School"
Dr. Jerome L. Schulman, Assistant Professor of Pediatrics and Psychiatry, Northwestern University Medical School, Chicago

12:00-1:30 p.m. Luncheon

1:30 p.m. "Collagen Diseases of the Skin"
Dr. Louis A. Brunsting, Head of Section of Dermatology, Mayo Clinic; Professor of Dermatology, Mayo Foundation, Rochester, Minnesota

2:00 p.m. "Diagnosis and Principles of Managing Nontuberculous Pulmonary Disease"
Dr. Peter V. Moulder, Associate Professor, Department of Surgery, University of Chicago School of Medicine, Chicago

2:30 p.m. "Management of Psychiatric Problems of the Aged"
Dr. Jack Weinberg, Clinical Associate Professor in Psychiatry, University of Illinois College of Medicine; Attending Psychiatrist, Psychosomatic and Psychiatric Institute for Research and Training, Michael Reese Hospital, Chicago

MEDICAL COLOR TELEVISION AND FILM LECTURES

Film lectures will be held each morning

The following Television Programs will be presented every afternoon: The Aching Back, Clinical Endocrinology, Office Gynecology, Hypertension, TVX,

Neurology, Ophthalmology, Clinical Laboratory Procedures, Surgery of the Biliary Tract, What's New in Dermatology?

REGISTRATION FEE $10.00

NO Registration fee for members of the Chicago Medical Society

An additional charge of $10.00 will be made for each of the INSTRUCTION COURSES

INSTRUCTION COURSES

COURSE NO. I 9:00-10:00 a.m. daily.

TITLE: Problems in Surgery

CO-ORDINATOR: Dr. Charles B. Puestow, Clinical Professor of Surgery, University of Illinois College of Medicine, Chicago.

FACULTY: Dr. Robert L. Schmitz, Dr. Eric Oldberg, Dr. William J. Gillesby, Dr. Charles B. Puestow.

POINTS TO BE COVERED: Wound infections in the use of antibiotics, head injuries, gastrointestinal hemorrhage, problems in biliary tract diseases.

COURSE NO. II 11:00-12:00 a.m. daily.

TITLE: Problems in Medicine

CO-ORDINATOR: Dr. Ralph E. Dolkart, Associate Professor of Medicine, Northwestern University Medical School.

FACULTY: Dr. Irving Schulman, Dr. James W. Limman, Dr. Wilson H. Hartz, Jr., Dr. Eugene L. Walsh, Dr. David W. Cugell, Dr. Thomas W. Shields, Dr. Joseph H. Skom, Dr. Albert B. Gerbie, Dr. David Yi-Yung Hsia, Dr. Harold L. Method, Dr. Ralph E. Dolkart.

POINTS TO BE COVERED: Seminars in hematology, pulmonary diseases, diabetes in pregnancy, and hormonal concepts in the treatment of disseminated carcinoma.

COURSE NO. III 1:30-2:30 p.m. daily.

TITLE: Problems in Obstetrics and Gynecology

CO-ORDINATOR: Dr. A. F. Lash, Professor of Obstetrics and Gynecology, University of Illinois College of Medicine; Professor of Gynecology, Cook County Postgraduate School of Medicine, Chicago.

FACULTY: The program will be presented by faculty members from the medical schools in Chicago.

POINTS TO BE COVERED: What is the abortion problem? Is intravenous pituitrin administration respectable obstetrics? Where does the positive Papp's smear lead? Can tubes in ovaries be salvaged in ectopic pregnancy and ovarian tumors? When and why uterine ligament shortening operation and ovarian resection? What to do for uterine bleeding. Practical sterility workup. Prophylactic or office gynecology.

COURSE NO. IV 4:00-5:00 p.m. Tues., Weds., Thurs.
Thurs.
2:30-3:30 p.m. Friday

TITLE: Problems in Pediatrics

CO-ORDINATOR: Dr. Noel G. Shaw, Assistant Professor of Pediatrics, Rush, University of Illinois College of Medicine, Chicago.

FACULTY: Dr. Mila I. Pierce, Dr. Benjamin M. Gasul, Dr. I. Pat Bronstein, Dr. E. Robbins Kimball, Dr. Herman F. Meyer, Dr. Eugene T. McEnery.

POINTS TO BE COVERED: Diseases of blood in infancy and childhood, Heart disease in infants and children (An evaluation of the reliability, and limitations and diagnosis based on physical, roentgen ray, and electrocadiographic findings in the past 300 years), endocrine diseases of childhood, feeding problems in infancy and childhood, breast feeding, formulas, psychologic aspects of feeding problems in the preschool child and in older children.

BRING THE LADIES

The Women's Auxiliary to the Chicago Medical Society
Clinical Conference Activities

March 1, Tuesday — Registration 9 a.m. to 4 p.m. in Hospitality Room

March 2, Wednesday — Tour of Merchandise Mart

March 3, Thursday — Luncheon and Fashion Show at the Morrison Hotel

The Women's Auxiliary to the Chicago Medical Society is happy to act as hostess during these clinical conference days. We look forward to entertaining you while your husbands are busy at meetings. Get your tickets for tours, luncheon, and television shows in the Hospital Room, Palmer House. Come and enjoy these days with us.

Mrs. Charles W. Stigman, chairman, ladies' activities, Mrs. W. J. Wanninger, co-chairman; Mrs. Joseph A. Cari, chairman, registration, Mrs. Sherman C. Arnold, co-chairman; Mrs. John M. Tindal, chairman, entertainment, Mrs. Richard E. Westland, co-chairman; Mrs. Roland Loring, chairman, luncheon and fashion show; and Mrs. Joseph Shanks, publicity.

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Clinical reviews at Mayo

The Mayo Clinic and Mayo Foundation for Medical Education and Research will present a program of lectures and discussions on problems of current interest in general medicine and surgery, April 4-6, at Rochester, Minn.

Members of the American Academy of General Practice and the College of General Practice of Canada will receive 21 hours of category I credit for attendance. There will be no fee.

Due to the limited number of physicians who can be accommodated, requests for reservations should be sent to the Clinical Review Committee, Mayo Clinic.

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Postgraduate course on fractures

The Chicago Committee on Trauma of the American College of Surgeons will hold its 4th Postgraduate Course on Fractures and Other Trauma, April 27-30, at the John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago.

Chicago's five medical schools and leading

hospitals will provide speakers. There also will be speakers from other parts of the country. The registration fee will be $50; residents will be admitted free.

For further information, write to Dr. John J. Fahey, chairman, 1791 West Howard Street, Chicago 26.

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Eye, ear, throat meetings

The Gill Memorial Eye, Ear, and Throat Hospital, Roanoke, Va., will hold its 33rd annual spring congress in ophthalmology and otolaryngology, April 4-9. Among the 17 guest speakers will be Dr. George E. Shambaugh Jr., Chicago.

Further information may be had by writing to the superintendent, P. O. Box 1789, Roanoke.

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Greenbrier Hotel, White Sulphur Springs, W. Va., April 10-12. Among the guest speakers will be Dr. Oscar T. Becker, clinical professor of otolaryngology, University of Illinois College of Medicine.

Further information may be had by writing to Dr. Albert C. Esposito, secretary, First Huntington National Bank Building, Huntington 1, W. Va.

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Examination in obstetrics

The American Board of Obstetrics and Gynecology will hold Part II examinations, oral and clinical, at the Edgewater Beach Hotel, Chicago, April 11-16. Eligible candidates will be notified.

The deadline for applications for 1961 examinations is August 1. These should be sent to Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6.

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Michigan clinical institute

Practical application of medical advances will be considered at the 1960 Michigan Clinical Institute, to be held March 8-11 at the Sheraton-Cadillac Hotel, Detroit. The subjects will include cancer, trauma, juvenile delinquency, the heart and rheumatic fever, internal medicine, and obstetrics and gynecology.

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Awards for surgery research

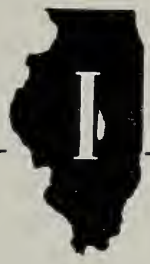
Two prizes of $300 each "for meritorious investigation in some phase of surgery or in the allied specialties of surgery" will be awarded in 1960 by the Woman's Auxiliary of the United States Section, International College of Surgeons.

The competition is open to physicians who have completed their internship or a year of residency within the last five years.

Further information may be had by writing to Dr. Horace E. Turner, ICS, 1516 Lake Shore Drive, Chicago 10.

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AT THE EDITOR'S DESK



IT is interesting to speculate how many stilbestrolized chickens a menopausal woman would have to consume to be relieved of her hot flashes. She would become so sated with chicken, her flashes would be insignificant in comparison. Women are voters and Congress will need much more evidence than we have at present to show that estrogens in therapeutic doses in menopausal women induce cancer before they eliminate stilbestrol from the pharmacopoeia.

The majority of news releases reaching this desk during the past month came from governmental agencies. The U.S. Department of Health, Education, and Welfare sent out a chronology relating to the use of diethylstilbesterol in poultry and meat animals. It is typical of the steps our food and drug administration is taking to comply with the Food Additives Amendment of 1958 to the Federal Food, Drug, and Cosmetic Act. The following excerpts from this material demonstrate the problem:

Diethylstilbestrol is a synthetic hormone-like substance with extrogenic or female hormone activity.

In 1938 the Federal Food, Drug, and Cosmetic Act replaced the Federal Food and Drugs Act of 1906. The new law contained for the first time a requirement placing on drug manufacturers the burden of proof to show that any new drug is safe before it is marketed [Section 505]. Under this requirement, a manufacturer of a new drug submits a new-drug application containing, among other things, reports of animal tests, clinical studies, or other research to show that the drug will be safe under the proposed directions and conditions of use. If the evidence is convincing, the application is allowed to become effective and the drug may be marketed. If the evidence of safety is not convincing, the application is denied, and marketing of the drug in interstate commerce is a violation of the law. This section of the law provides, however, that once a new-drug application has been made effective, the burden of proof shifts to the government to show that the drug is unsafe in an action to revoke the application.

In 1941, acting under the New Drug Section, the Food and Drug Administration permitted 11 firms to begin marketing diethylstilbestrol for clinical use. The drug is now widely used in medicine, subject to strict supervision by physicians.

In May 1945, the FDA received the first applications for the use of diethylstilbestrol pellets in poultry. Directions called for implanting the pellet under the skin, at the base of the skull of poultry, so that any unabsorbed pellet residue would be removed with the head at the time of slaughter. This application became effective January 30, 1947, after almost two years of study. It was known at that time that oral administration of diethylstilbestrol had been shown to produce cancer in test animals. However, at that time it was believed that no significant residues of the drug would remain in the edible tissues of the treated birds. Several additional applications covering similar products and uses have been made effective. It is estimated that about

one per cent of the poultry going to market has been treated with diethylstilbestrol.

In 1948, the Food and Drug Administration published a statement of policy in the *Federal Register* advising manufacturers of veterinary drugs that all new-drug applications for veterinary products intended to effect physiological changes in farm animals (i.e., to promote fattening, increase milk or egg production, etc.) would have to include evidence that no residue would remain in human food products derived from treated animals.

In 1950-51, a select committee of the House of Representatives, under the chairmanship of the Hon. James J. Delaney, conducted an investigation of chemicals being used in foods. A representative of one of the manufacturers of diethylstilbestrol for implantation testified that evidence had been developed showing that minute amounts of diethylstilbestrol remain in the liver of treated birds. The residue was thought to be of the order of 20 to 40 parts per billion. Although interpretation of the data was questionable, the amount of residue was considered, for all practical purposes, the same as zero. These data were submitted to the department as assurance that no residue would remain in the edible parts of the bird. There was conflicting testimony before the Delaney Committee regarding the safety to the consumer of diethylstilbestrol-treated poultry.

In 1954, an application was permitted to become effective for the marketing of diethylstilbestrol for addition to the feed of beef cattle. Evidence submitted with the application showed no detectable residues in the meat of the animals when the treated feed was withdrawn 48 hours prior to slaughter, as called for in the directions. Since then many similar applications have been made effective. All are based on absence of detectable residues in meat from the treated animals. It is estimated that 80 to 85 per cent of beef cattle are fed now on feed containing diethylstilbestrol. Commercial feeding and slaughtering practices are such that there is every reason to believe that directions for withdrawal of the medicated feeds at least 48 hours before slaughter are followed, and that the meat is free of detectable residues of diethylstilbestrol.

In December, 1955 the FDA permitted the marketing of diethylstilbestrol pellets for implantation in the ear of beef cattle. Evidence submitted showed that this use resulted in no detectable residues in meat of the treated animals. Directions for use, as specified in the application, state that the ear is not to be used for food for man or animal.

By 1957 a reliable method of assay for diethylstilbestrol in animal tissues was developed, and the FDA applied this method to learn whether the supposed zero levels actually were being achieved in cooked beef and poultry. No residue was found in beef; but in treated chickens, 20 to 30 parts per billion of residues were found in the liver, and 35 to 100 parts per billion in the skin fat. When this evidence was accumulated in 1957, the Commissioner of Food and Drugs posed the problem to his scientific advisors whether it could be shown scientifically that these minute residue levels were unsafe. On the basis of evidence available at that time, he concluded that the new-drug applications could not be revoked.

In 1957, the Council on Foods and Nutrition of the American Medical Association authorized publication of a report, "Estrogen Residues in Meat — Public Health Aspects" prepared by Dr. George M. Briggs of the Nutrition and Endocrinology Division of the National Institutes of Health, and co-sponsored by the Nutrition Foundation, Inc. (J.A.M.A. *164*:1473-6, July 27, 1957). This report concluded that no hazard to man was presented by the administration of compounds with estrogenic activity to beef cattle and poultry to improve weight gains and feed efficiency.

In 1957, the FDA permitted the marketing of diethylstilbestrol for addition to the feed of sheep, again under conditions that leave no residue in the meat.

In September 1958 Congress enacted the Food Additives Amendment to the Federal Food, Drug, and Cosmetic Act, which requires premarketing safety clearance for food additives along the lines of the requirements established for new drugs by the 1938 Act. It places on the manufacturer the burden of proof of safety.

Two special sections, however, are pertinent in this connection:

1. The amendment provides, among other things, that "no regulation permitting the use of a food additive may be issued if a fair evaluation of the data before the Secretary fails to establish that the proposed use of the food additive, under

the conditions of use to be specified in the regulation, will be safe: *Provided,* that no additive shall be deemed to be safe if it is found to induce cancer when ingested by man or animal, or if it is found, after tests appropriate for the evaluation of the safety of food additives, to induce cancer in man or animal."

2. The law exempts from the definition of a food additive, "any substance used in accordance with a sanction or approval granted prior to the enactment of this paragraph pursuant to this Act."

Thus under this latter provision a product previously permitted under a new — drug application is not a food additive; and in any revocation of a new — drug application the burden of proof shifts to the government, which must then show the product unsafe.

In May 1959, the FDA published in the *Federal Register* a statement of policy in which it interpreted the first of the sections quoted above as prohibiting it from making effective any further applications for the addition to animal feed or any use which leaves residues in human food of any drugs that produce cancer in man or animal when ingested. All prior sanctions for such substances would be reviewed, and if it were concluded that revocation of new-drug applications would be required in the proper administration of the Federal Food, Drug, and Cosmetic Act, appropriate action would be taken.

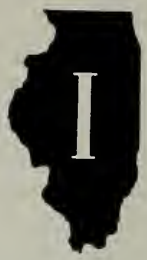
The food and drug industries have been shaken by the Delaney clause of the Food Additives Amendment (1958) of the Federal Food, Drug, and Cosmetic Act "no (food) additive shall be deemed to be safe if it is found to induce cancer when ingested by man or animal. All additives from the weed killer used in cranberry production to the pigments used in coloring vitamin capsules and lipstick are included.

The government's attitude toward substances that might cause cancer is described by Secretary Arthur S. Flemming: "No one knows how much or how little of a substance that induces cancer in an animal — when included in the diet — is necessary to induce cancer in man. Some people take issue with that statement. . . . I think it is perfectly all right for scientists and people in the medical profession to argue about that question. But our point is that while the argument is going on, the consumer should not in effect be asked to serve as a guinea pig."

The present agricultural use of stilbestrol, according to Flemming is in "the raising of beef cattle, either as an addition to cattle feed or as pellets implanted in the ears of cattle." No residues are found in beef, mutton, or lamb, even though 80-85 per cent of beef receive the hormone in feed.

Approximately one per cent of the chickens grown in this country have received stilbestrol and residues of the hormone are found in the skin, livers, and kidneys of the slaughtered birds. None was found in the white or dark meats. Nevertheless, the manufacturers of stilbestrol and representatives of the poultry industry have agreed to discontinue its use. This is a voluntary action and the secretary wants it known that consumers can buy meat and poultry with full confidence in their safety and wholesomeness.

NEWS of the STATE



COOK

Honored. Dr. Edwin F. Hirsch, consulting pathologist, Presbyterian-St. Luke's Hospital, and chairman of our editorial board was awarded the George Howell Coleman Medal of the Institute of Medicine of Chicago for "outstanding contributions to the welfare of the community above and beyond the practice of his profession." Dr. Hirsch has led the movement to improve the operation of the coroner system in Illinois.

Cancer Study. Dr. Emil H. Grubbe, internationally noted Chicago physician who has had 93 operations for cancerous burns suffered more than 50 years ago when he pioneered in using X-rays for human therapy allocated the bulk of his estate to cancer researchers at the University of Chicago. The gift, valued at $157,992 in bonds, stocks, and mutual fund holdings is in the form of a trust. Dr. Grubbe will receive the net income from the assets during his lifetime, after which the estate becomes the property of the university.

Clinical Conference. The Chicago Ophthalmological Society held its annual clinical conference February 12 and 13 in Chicago. The guest speakers included Drs. Walter S. Atkinson, Watertown, N.Y.; Gilbert Baum, Port Chester, N.Y.; James Bennett, Cleveland, Ohio; Paul Cibis, St. Louis, Mo.; Robert Hollenhorst, Rochester, Minn.; Isaac Tassman, Philadelphia; and Bertha A. Klien, Peter C. Kronfeld, Oscar Sugar, and Derrick T. Vail of Chicago. The subjects included a symposium on retinal disorders, ophthalmodynamometry in intracranial vascular disease, observation on cataract surgery, ultrasonography in clinical ophthalmology, photocoagulation of iris and retina, a new surgical approach to lacrimation problems, and a neurosurgeon looks at ophthalmology.

Annual Lecture. The second annual Nelson M. Percy lecture was given under the auspices of the Nelson M. Percy Research Foundation Jan. 15 in the auditorium of the Augustana Hospital. Dr. Erwin R. Schmidt, professor of surgery and head of the department of surgery, University of Wisconsin, spoke on "Thirty Years' Experience with Surgical Anesthesia."

Florida Lectures. Dr. Maurice H. Cottle, professor of rhinology and otolaryngology at the Chicago Medical School, presented three lectures at the Florida Midwinter Seminar in Ophthalmology and Otolaryngology at Miami: "Premaxilla Approach to Septum Surgery — A New Operation," "Surgery for Atrophic Rhinitis and Septum Perforations," and "Pressure and Flow Pressure Testing of Nasal Function — Correlation with Nasal Surgery."

January Society Meeting Programs. Chicago Orthopaedic Society — Drs. Edward A. Millar and Arthur R. Colwell, Jr.: "Rehabilitation of Juvenile Rheumatoid Arthritis," and Dr. Hampar Kelikian: "Surgical Lesions Simulating Arthritis." This meeting was held jointly with the Chicago Rheumatism Society.

Chicago Rheumatism Society — Dr. Frank R. Schmid: "Clinical Implications of Abnormal Serum Globulins in Rheumatic Diseases," and Dr. Leif Sorensen: "The Pathogenesis of Gout."

Metropolitan Chicago Chapter of the American College of Surgeons — panel symposium: "Peptic Ulcer." Dr. Walter C. Alvarez was moderator, and the panelists were Drs. Henry K. Ransom, professor of surgery and surgeon University of Michigan Hospital, Ann Arbor; Walter L. Palmer, Richard T. Crane professor of medicine, University of Chicago; Chester C. Guy, clinical professor of surgery, University of Illinois; and Irving Stein, Jr., assistant professor of surgery, Northwestern University Medical School.

Chicago Urological Society — Dr. John K. Lattimer, professor of urology, Columbia University College of Physicians and Surgeons: "Tuberculosis of the Genitourinary Tract."

Society of Medical History of Chicago — Dr. Samuel M. Bluefarb, associate professor of dermatology, Northwestern University Medical School: "History of Dermatology on Postage Stamps," and Dr. Samuel J. Zakon, professor of dermatology, Northwestern University Medical School: "Maimonides."

Chicago Surgical Society — Drs. A. Meyer and D. Kozoll: "Factors Influencing the Incidence and Mortality of Acute Perforated Gastroduodenal Ulcers;" Drs. A. Stemmer and E. Adams: "Incidence of Carcinoma at the Esophagogastric Junction in Short Esophagus;" Drs. S. J. Fogelson, C. R. Jackson, W. J. Norcross, and C. C. Guy: "Repair of Tissue Deficient Hernias by Aortic Implants;" and Drs. Robert P. Hohf and George C. Sutton: "The Experimental Use of a Vasopressor at the End of Temporary Aortic Occlusion."

Chicago Gynecological Society — Dr. John W. Huffman: "Diagnostic Problems in Pediatric Gynecology," and Dr. Michael P. MacLaverty: "Prolapse of the Umbilical Cord: A Study of 110 Cases."

Memorial Lecture. The 1960 annual D. J. Davis Memorial Lecture on Medical History will be given at 1:00 p.m., March 30 in Room 221 of the Dental-Medical-Pharmacy Building of the University of Illinois, 1853 West Polk Street, Chicago. The lecturer will be Dr. Barry J. Anson, chairman and Robert Laughlin Rea professor, department of anatomy, Northwestern University Medical School. His subject will be "Medieval Medicine: Pre-Christian Fabric and Present Day Remnants."

DEKALB

Meeting. Dr. John W. Sheagren, instructor in medicine, University of Illinois College of Medicine spoke on "Understanding Emotional Illness," at the January meeting of the De Kalb County Medical Society.

HENRY

Meeting. Dr. Thomas W. Carter, member of staffs of Lutheran and Public Hospitals in Moline and St. Anthony's, Rock Island, spoke on "Peripheral Vascular Surgical Emergencies," at the January meeting of the Henry County Medical Society.

JEFFERSON

Celebration. More than 200 grade school students sang "Happy Birthday Dr. Andy" on January 8 in Mt. Vernon. It was a surprise party for Dr. Andy Hall on his 95th birthday. He was brought to Eugene Field School where a school board member announced the new name — Dr. Andy Hall School.

LAKE

Meeting. Mr. P. M. O'Connell, executive director, Lake County Safety Commission, spoke on "The Activities of the Lake County Safety Commission in Highway Safety," at the January meeting of the Lake County Medical Society. Newly elected officers for the Society are: C. J. Foley, president elect; William E. Looby, vice president; Albert Behn, secretary; John Curns, treasurer.

LASALLE

Meeting. Dr. John J. Brosnan, assistant clinical professor of surgery, Stritch School of Medicine of Loyola University, spoke on "Fungous Diseases of the Chest," at the January meeting of the LaSalle County Medical Society.

MCDONOUGH

Meeting. Attorney Albert Scott, Canton, associate counsel, ISMS, spoke on "What the Forand Bill Means to You," at the January meeting of the McDonough County Medical Society.

PEORIA

Meeting. Mr. Walter Oblinger, assistant legislative council for the ISMS spoke on the "Program of Action for County Medical Societies Relating to the Forand Bill," at the January meeting of the Peoria Medical Society.

ROCK ISLAND

Meeting. Dr. Robert Jones, department of anesthesia, Mayo Clinic, spoke at the January meeting of the Rock Island County Medical Society.

SANGAMON

Meeting. Dr. J. A. Stocker spoke on "Some Observations on Histoplasmosis," at the January meting of the Sangamon County Medical Society. Also at this meeting, the annual memorial service was conducted by Reverend John W. Collins.

ST. CLAIR

Meeting. The St. Clair County Medical Society held its executive board meeting in January.

VERMILION

Meeting. Dr. Kenneth C. Johnston, associate professor of bronchoesophagology, University of Illinois College of Medicine, spoke on "Respiratory Tract Emergencies," at the January meeting of the Vermilion County Medical Society. The 1960 Society officers are: J. S. Curtis, president; A. J. Rarick, vice president; L. W. Tanner, secretary-treasurer.

WHITESIDE

Appointment. Dr. Robert Fielding, Sterling, has been appointed to the Advisory Board of the Institute for Juvenile Research.

WOODFORD

Meeting. Attorney Albert Scott spoke on the "Forand Bill," at the January meeting of the Woodford County Medical Society.

GENERAL

New Health Chief. Dr. Leroy Fatherree, Champaign, president of the American Association of Public Health Physicians, was appointed state director of public health by Governor Stratton. He will succeed Dr. Roland R. Cross, director for 19 years, who died November 28. Dr. Fatherree is a Mississippian, a graduate of the University of Tennessee and Harvard University, and has headed public health departments of Little Rock, Ark., Lincoln and Omaha, Neb., and Joliet. Dr. Roger Francis Sondag of Murphysboro was named assistant director. He is the public health department's regional officer for southern Illinois.

College Head. Dr. John Paul North will become director of the American College of Surgeons effective Jan. 31, 1961. He will succeed Dr. Paul R. Hawley, who has been director of the college, 40 E. Erie, Chicago, since 1950.

South America. Dr. Tibor Benedek, editor-in-chief of Mycopathologia et Mycologia Applicata; associate clinical professor of dermatology, Stritch School of Medicine of Loyola University, was an official guest of the Venezuelan Society of Tuberculosis. He participated in the deliberations and discussions on "Systemic Mycoses of the Lungs," which covered the second half of the convention held at Valencia, Venezuela.

"Your Health Comes First" over Radio Chicago WJJD:

February 24 at 6:45 p.m.—Donald I. Bell associate in medicine, Northwestern University Medical School, will discuss "Diabetes."

This is a public service program sponsored by the Illinois State Medical Society in co-operation with Radio Chicago WJJD.

SPEAKERS' BUREAU ACTIVITIES

Date:	January 13, 1960
Speaker:	Thomas W. Carter, member of staffs of Lutheran and Public Hospitals, Moline
Topic:	Peripheral Vascular Surgical Emergencies
	Henry County Medical Society in Kewanee
Date:	January 14, 1960
Speaker:	John J. Brosnan, assistant clinical professor of surgery, Stritch School of Medicine of Loyola University
Topic:	Fungus Diseases of the Chest
	LaSalle County Medical Society in Ottawa

Date: January 21, 1960
Speaker: Jack Weinberg, clinical associate professor of psychiatry, University of Illinois College of Medicine
Topic: Psychological Dynamics of Aging
Knox County Medical Society in Galesburg

Date: January 21, 1960
Speaker: H. Worley Kendell, Medical Director, Institute of Physical Medicine and Rehabilitation, Peoria
Topic: Organization and Goals of the Rehabilitation Center, Whiteside-Lee County Medical Societies in Sterling

Date: February 8, 1960
Speaker: Charles I. Fisher, associate in medicine, Northwestern University Medical School
Topic: High Blood Pressure
Ner Tamid Golden Age Club in Chicago

Date: March 5, 1960
Speaker: Thomas F. Kruchek, clinical assistant in psychiatry, Stritch School of Medicine of Loyola University
Topic: Psychiatry and Religion
Pearl Franklin Hadassah in Chicago

Date: March 16, 1960
Speaker: Lawrence Breslow, clinical assistant professor of pediatrics, University of Illinois College of Medicine
Topic: Problems of Teen-age Children
Skokie Chapter City of Hope in Evanston

Date: March 17, 1960
Speaker: Fred P. Long, Director, Peoria and Peoria County Health Department
Topic: Programs of the Peoria City and County Health Department, Stephenson County Medical Society in Freeport

DEATHS

Finis E. Barnes, Charleston, who graduated at the American Medical College, St. Louis, in 1903, died September 30, aged 86.

Chester John Challenger*, Park Ridge, who graduated at Dearborn Medical College in Chicago in 1906, died December 29, aged 76. He was chief radiologist at St. Mary of Nazareth Hospital since 1921 and had been a member of the staff for 39 years. He had served as past president of St. Mary's staff, and was a faculty member of Loyola University School of Medicine from 1938 to 1942.

Tracy Hamilton Clark, retired, Chicago, who graduated at Northwestern University Medical School in 1898, died December 29, aged 87. He had practiced medicine in the Ravenswood area for 46 years before his retirement 15 years ago.

Elliott S. Denney*, Aurora, who graduated at Harvard Medical School in 1920, died December 23, aged 67. He was a member of the staff of Copley Memorial Hospital and a former chief of staff. He was also health director of Mooseheart, a school and orphanage near Aurora operated by the Moose lodge, and Moosehaven, a home for elderly persons living at Orlanda, Fla.

Lee L. Dennison, Lake Fork, who graduated at Louisville Medical College in 1897, died recently, aged 93.

Rollae Dean Finch*, Flora, who graduated at St. Louis University School of Medicine in 1912, died September 22, aged 72. He was a member of the staff of the Clay County Hospital.

Charles E. Franklin*, Oak Park, who graduated at the University of Cincinnati College of Medicine in 1930, died January 6, aged 55. He was a past president of the Oak Park Hospital staff and of the Aux Plaines Branch of the Chicago Medical Society.

Richard S. Grant*, retired, Chicago, who graduated at Meharry Medical College in 1904, died December 31, aged 85. He was a former president of the National Association for the Advancement of Colored People in Rockford, where he had been active in civic affairs, until he retired five years ago and moved to Chicago.

Seymour D. Guten*, Chicago, who graduated at the Chicago Medical School in 1946, died December 15, aged 41. He was a member of the staff of Edgewater Hospital.

Frank Heda*, Chicago, who graduated at Loyola University School of Medicine in 1916, died December 15, aged 68. He was a charter member and director of Roseland Community Hospital, and a past president of the Calumet Branch of the Chicago Medical Society.

*Indicates member of the Illinois State Medical Society.

Roy M. Hohman*, Chicago, who graduated at Rush Medical College in 1931, died December 23 while driving his car. He was a member of the staff of the Evangelical Hospital, aged 53.

Jasper M. James*, Henning, who graduated at Washington University School of Medicine, St. Louis, in 1905, died Nov. 20, aged 83.

Frank C. Leeming*, Chicago, who graduated at the University of Louisville School of Medicine in 1921, died January 10, aged 66. He was former chief of staff at Little Company of Mary Hospital and co-chairman of its pediatrics department. He was formerly a member of the faculty of Loyola University School of Medicine.

Joshua Magidson*, Chicago, who graduated at the Chicago Medical School in 1951, died December 23, aged 38. He was a member of the staff of the Field Clinic, and instructor in medicine at Northwestern University Medical School.

William J. Mulholland*, Chicago, who graduated at the University of Illinois College of Medicine in 1916, died December 22, aged 71. He was a member of the staff of St. Bernard's Hospital.

Theodore S. Proxmire*, Lake Forest, who graduated at the Hahnemann Medical College and Hospital in 1904, died December 16, aged 78. He had practiced medicine in Lake Forest for 55 years, and was for many years chief of staff at Lake Forest Hospital. During World War I he commanded the Army general hospital at Fort Sheridan. He was founder and director of Lake County Tuberculosis Sanitarium, Waukegan, and a director of the Allendale School for Boys in Lake Villa. He was the father of Sen. William E. Proxmire (D-Wis.).

Ralph H. Scull*, retired, Chicago, who graduated at Rush Medical College in 1929, died December 16, aged 62. He was former head of the department of dermatology at Rush.

Frederick L. Stiers*, East Peoria, who graduated at Washington University School of Medicine, St. Louis, in 1903, died recently, aged 84.

Karl H. Tannenbaum, Frederick, Md., of Chicago until 1954, who graduated at Johns Hopkins University School of Medicine in 1918, died December 23 in Chicago Wesley Memorial Hospital, aged 67. He was formerly a staff member of St. Luke's Hospital and taught at Northwestern University Medical School.

John T. Wead*, Wyoming, who graduated at the University of Illinois College of Medicine in 1924, died recently, aged 63.

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BOOK REVIEWS



CUTANEOUS MANIFESTATIONS OF THE MALIGNANT LYMPHOMAS. Samuel M. Bluefarb, M. D. $15.50. Pp. 534. Springfield, Ill., Charles C. Thomas, 1959.

This volume deals with the cutaneous and mucous membrane manifestations of mycosis fungoides, Hodgkin's disease, and lymphosarcoma. The history, pathogenesis, pathology, cutaneous and mucous membrane lesions, diagnosis and differential diagnosis, prognosis, and external and systemic therapy of each entity are discussed thoroughly. The medical literature from the earliest to the most recent report has been summarized exhaustively or quoted.

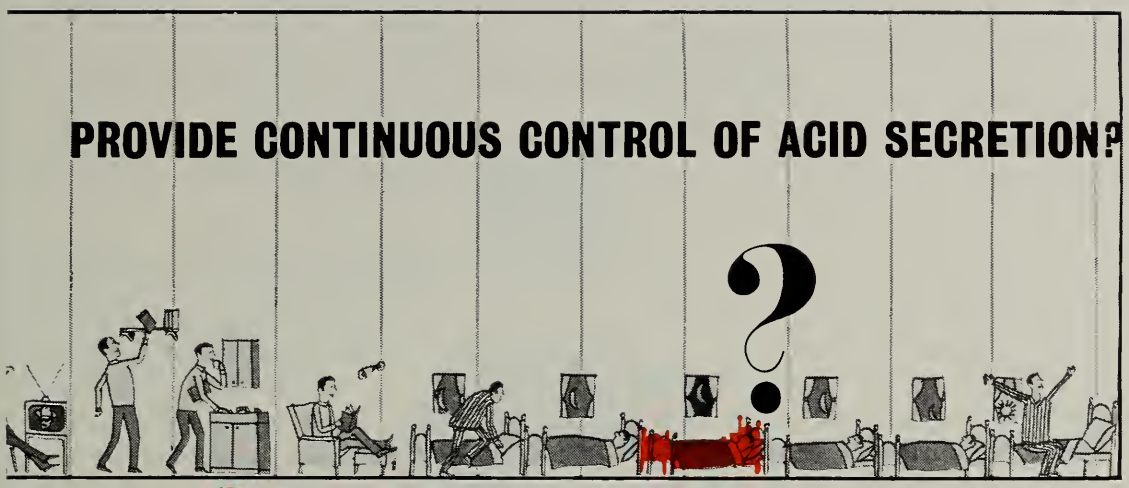
Although the book was written as part of a series devoted primarily to the cutaneous manifestations of reticuloendothelial diseases, space also is devoted to systemic clinical, laboratory, and pathologic findings. The concluding chapter is concerned with impaired immunological responses in patients with malignant lymphomas. The entire text reflects the great experience and clear judgment of the author.

Although there has been some support for Symmers' opinion that mycosis fungoides is a nonexistent clinical and pathologic entity, Bluefarb strongly supports the opposite and prevalent viewpoint. In particular, he details carefully the characteristic pathological changes in the skin to show that the findings do not resemble leukemia, Hodgkin's disease, or any variety of sarcoma — at least, in the later stages of mycosis fungoides. In his description of the morphologic varieties of premycotic lesions and the infiltrative and tumor stages of the disease, the author also dispels two widely held views concerning mycosis fungoides. He states that patients who develop cutaneous tumors as the initial lesions ("d'emblee" type) are always found to have lymphosarcoma, or rarely, Hodgkin's disease. He maintains also that erythroderma, or exfoliative dermatitis, is not a form of classical mycosis fungoides but actually is a clinical manifestation of Hodgkin's disease, chronic lymphatic leukemia, or lymphosarcoma. Bluefarb states: "There are no substantiated reports of cases having the clinical picture of erythroderma or the 'd'emblee' type showing postmortem findings of mycosis fungoides."

In the chapters dealing with the cutaneous lesions of Hodgkin's disease and lymphosarcoma, the author strongly emphasizes that in many cases the cutaneous features are the first discernible signs of the disease. The skin changes are divided into two main groups: the specific lesions that histologically display the cell type characteristic of the underlying malignant disease, and the nonspecific or toxic lesions that present a nonspecific histologic picture. In the

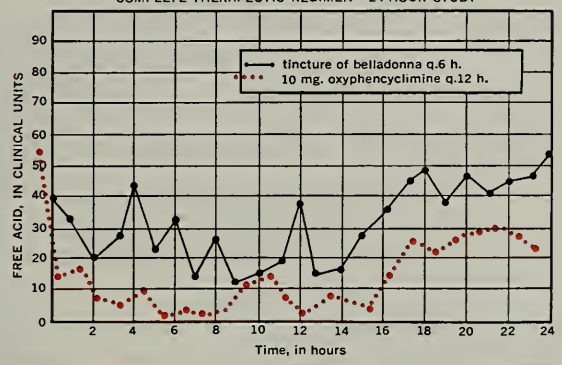
(*Continued on page 76*)

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References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

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reviewer's opinion there is some reason to assume that these toxic eruptions result from defense reactions of the skin to colonization by foreign cells. The author does not carry this view into his classification but includes thrombocytopenic purpura and herpes zoster, for example, in the nonspecific category, whereas such entities might better be placed in a separate heterogenous group. At times the nonspecific dermatoses (eczematous, vesicular) may show histologic changes typical of the underlying diseases, and the author has elected to create a third category of lymphogranulomatids, or id reactions, for disorders in this group. The entire gamut of clinical and pathological changes of all forms of cutaneous lesions in Hodgkin's disease and lymphosarcoma has been described meticulously and thoroughly.

The book is profusely illustrated and many of the photographs and microphotographs are of excellent quality. The bibliography is the most complete so far been assembled. No doubt the few printing errors will be corrected in the next printing.

As a comprehensive study, the volume can be highly recommended to the general practitioner, the internist, and the dermatologist.

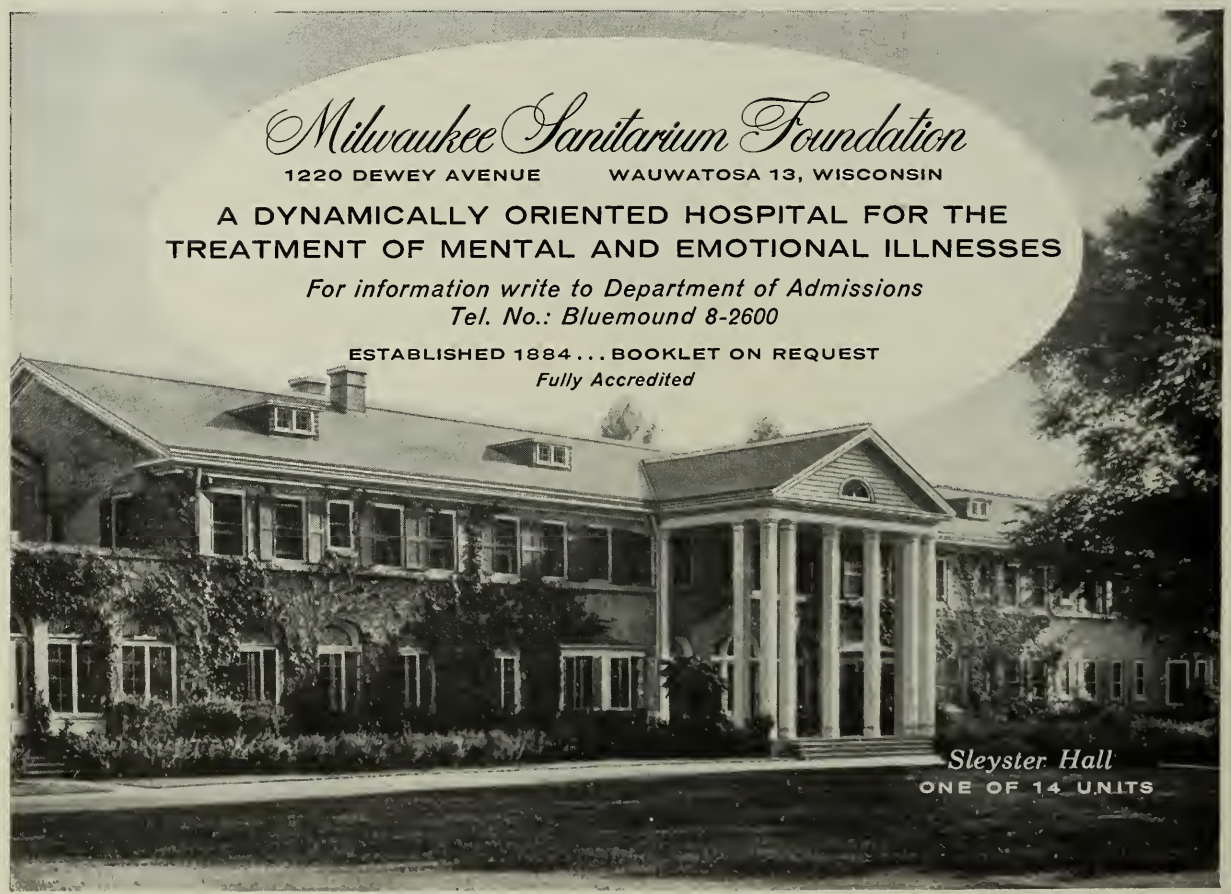
Frederick D. Malkinson, M.D.
Assistant Professor of Dermatology,
University of Chicago.

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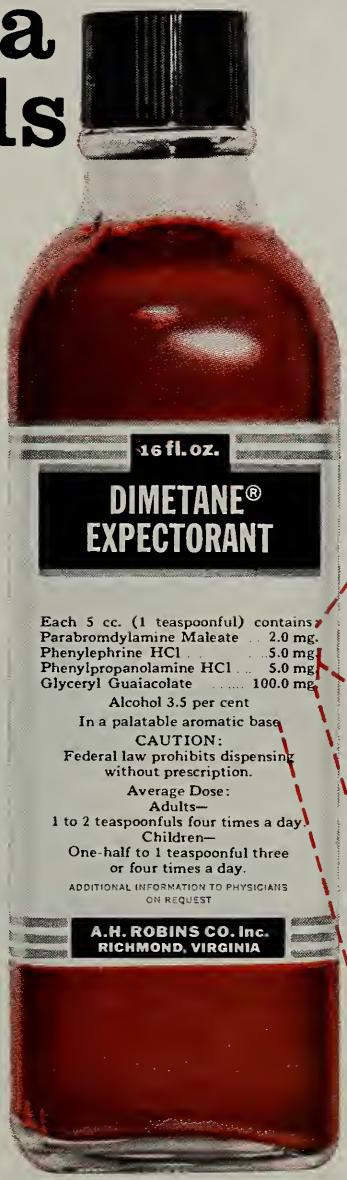
PYELONEPHRITIS. Fletcher H. Colby, M.D. $7.50. Pp. 214. Baltimore, Williams & Wilkins, 1959.

This monograph summarizes the important aspects of pyelonephritis. The pathology, bacteriology, symptomatology, techniques of diagnosis, and principles of treatment of both the acute and chronic forms are discussed. Emphasis is placed upon the various important conditions predisposing to the development of serious renal infection, such as obstructive lesions of the urinary tract and diabetes. An entire chapter is devoted to pyelonephritis in pregnancy. Another presents the special aspects and importance of this disease in infancy and childhood. The causal relationship of pyelonephritis to hypertension is discussed in a stimulating fashion. Throughout

(*Continued on page* 80)



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the monograph, well illustrated case histories are utilized to emphasize various important features of pyelonephritis. In addition, the author often employs to advantage summaries of the results of his personal experiences.

The combination of theoretical and practical considerations of pyelonephritis presented in this monograph, in a manner suggesting a long and thoughtful association with this disease, is refreshing. This book should have a widespread appeal to members of the medical profession.

John T. Grayhack, M.D.
Department of Urology
Northwestern University
Medical School

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Measles and distemper

Measles and canine distemper probably are related. They have in common a similar incubation period, similar localization and exanthem, demyelinating encephalitis, and characteristic giant cells. *Hobart A. Reimann, M.D. Infectious Diseases. A.M.A. Arch. Int. Med. July 1959.*

Ulcerative colitis

Long term continuous treatment with prednisolone of a series of 19 patients suffering from chronic ulcerative colitis, using a high initial dose and gradual reduction to a maintenance dose, has induced a remission of the disease in every case. Threatened relapses invariably were aborted by a temporary increase in dosage and so far, with the period of observation ranging from 18 months to two and a half years, the patients still on a regular maintenance dose remain well. *A. Morton Gill, M.D. and W.I. Kenyon, M.B. Continuous Use of Prednisolone in the Treatment of Ulcerative Colitis. Am. J. Gastroent. Dec. 1959.*

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More oil

Drug stores sold more mineral oil in 1956 than they did in either 1957 or 1958. The reason is obvious. With all forms of oil being spread by Republican and Democratic hopefuls, it's only logical that tanks of mineral oil would help grease the political skids. *Editorial. Pills and Politics. GP Nov. 1959.*

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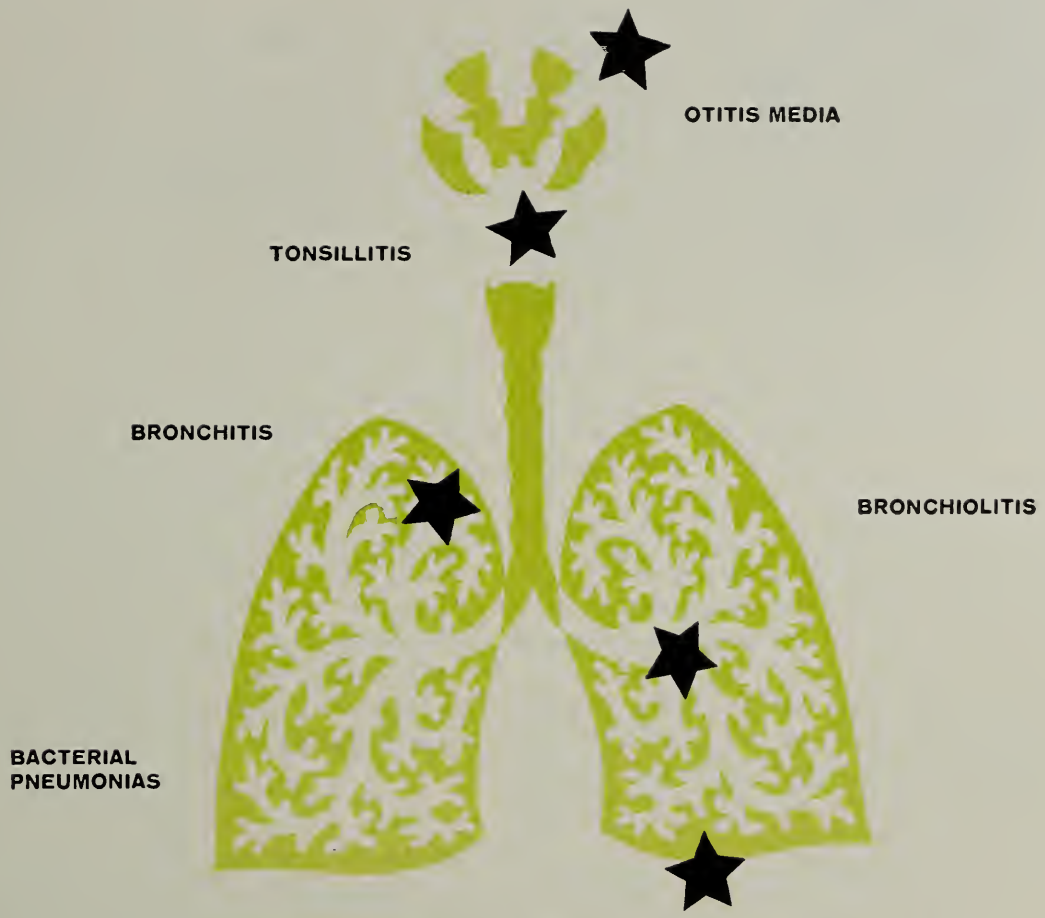
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1. Lysaught, J. N., and Cleaver, W.: Proceedings of the Detroit Symposium on Antibacterial Therapy (Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959).

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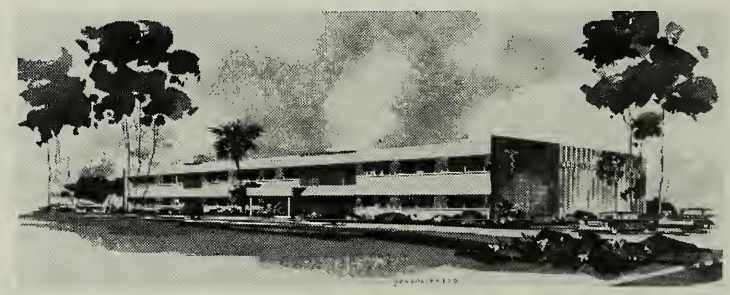
E.E.G. findings in murderers

In this particular piece of research we hit upon what subsequently proved to be an exceedingly significant question simply by reviewing the history and personal circumstances of each individual in terms of the crime with which he or she was charged. We were in this way able to make a number of separate clinical categories, each of which could be studied separately in terms of the E.E.G. records of the particular group.

These categories included what we called accidental murderers, people who had been involved in action resulting in loss of life while already engaged upon the commission of a felony, and who, while indisputably criminal, were not necessarily to be regarded as willful murderers at all. A second category was that of deliberate motivated murder: people who had committed murder for reasons they and everyone else concerned could relate to the basis of the crime. Two important categories remained: motiveless murderers, who had committed sudden explosive acts of violence causing the death of another person for no reason which they or anyone else could put forward; and people who were at the time of the killing recognizably insane.

The group of murderers whose crime was regarded as incidental or even accidental in the course of the commission of another felony showed a 25 per cent incidence of E.E.G. abnormality — equal to that of the prison population as a whole. In those who had committed a murder under stress of considerable personal provocation, and were to this extent clearly motivated, the proportion of abnormality was roughly 17 per cent; considerably below the average for the prison population as a whole and not much above that of the ordinary population chosen at random. But in the apparently motiveless murderers, the people who exploded into an act of violence without any kind of provocation other than perhaps the immediate stress of sexual excitement, resentment, or exhaustion, the percentage of abnormality was 73, the highest recorded in any group of individuals selected in any way, if one excludes known epileptics who have commit-

(*Continued on page* 86)



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performance



genitourinary infection. Roberts, M. S.; Seneca, H., and Lattimer, J. K.,[1] New York, N. Y.—Ninety-one per cent of the Gram-positive and 27 per cent of the Gram-negative, among 66 organisms cultured from genitourinary infection, responded to DECLOMYCIN. Serum antibiotic activity was found three times greater than with tetracycline.

toleration. Boger, W. P., and Gavin, J. J.,[2] Norristown, Pennsylvania—Side effects with DECLOMYCIN were minimal. When dosage was 0.5 to 1 Gm. daily in divided doses, only two of 82 patients exhibited nausea.

activity level sustentation. Kunin, C. M.; Dornbush, A. C., and Finland, M.,[3] Boston, Massachusetts—Of the four tetracycline analogues, DECLOMYCIN Demethylchlortetracycline showed the longest sustained activity levels in the blood.

gonococcal infection. Marmell, M., and Prigot, A.,[4] New York, N. Y.—Of 63 cases of gonorrhea, 61 promptly responded after short courses of DECLOMYCIN. Therapeutic effect was found equal to that of intramuscular penicillin.

bronchopulmonary infection. Perry, D. M.; Hall, G. A., and Kirby, W. M. M.,[5] Seattle, Washington—Of 30 cases of acute bacterial pneumonia, all were afebrile following two to 10 days of treatment with DECLOMYCIN. Results were good in 21.... All of six patients with acute bronchitis responded promptly.

pediatric infection. Fujii, R.; Ichihashi, H.; Minamitani, M.; Konno, M., and Ishibashi, T.,[6] Tokyo, Japan—In 309 pediatric patients with various infections, DECLOMYCIN was effective in 75 per cent.

urogenital infection. Vineyard, J. P.; Hogan, J., and Sanford, J. P.,[7] Dallas, Texas—Clinical response in pyelonephritis correlated well with results of *in vitro* sensitivity tests, which showed some strains of *A. aerogenes*, Proteus and Pseudomonas more susceptible to DECLOMYCIN Demethylchlortetracycline than to its analogues.

pneumonia. Duke, C. J.; Katz, S., and Donohoe, R. F.,[8] Washington, D. C.—Results were satisfactory in all but two of 32 cases of acute bacterial pneumonia, of which only 11 were uncomplicated. No side effects were observed.

brucellosis. Chávez Max G.,[9] Mexico, D. F., Mexico—All of nine patients with *Br. melitensis* infection were afebrile after five days on DECLOMYCIN. Blood cultures were negative in all cases on the 20th day. Side effects were limited to slight temperature increases which abated in four days.

pustular dermatosis. Blau, S., and Kanof, N. B.,[10] New York, N. Y.—Results with DECLOMYCIN were excellent in both of two cases of impetigo, one of two cases of folliculitis, six of nine cases of furunculosis, all of three cases of acne rosacea and 26 of 45 cases of acne vulgaris. Overall, results were excellent or good in 85 per cent.

antibacterial spectrum. Finland, M.; Hirsch, H. A., and Kunin, C. M.,[11] Boston, Massachusetts—DECLOMYCIN Demethylchlortetracycline was found the most effective of the tetracycline analogues against two-thirds of 680 normally sensitive strains of 15 separate species.

the over-all picture. Combined results reported by 210 clinical investigators[12]—DECLOMYCIN produced a favorable response (cured or improved) in 87 per cent of 1,904 patients. Two-thirds of the patients received one capsule every six hours. Treatment was continued for as long as 180 days, but was between three and eight days in most. Side effects were seen in 9.9 per cent, but necessitated discontinuance of treatment in only 1.8 per cent.

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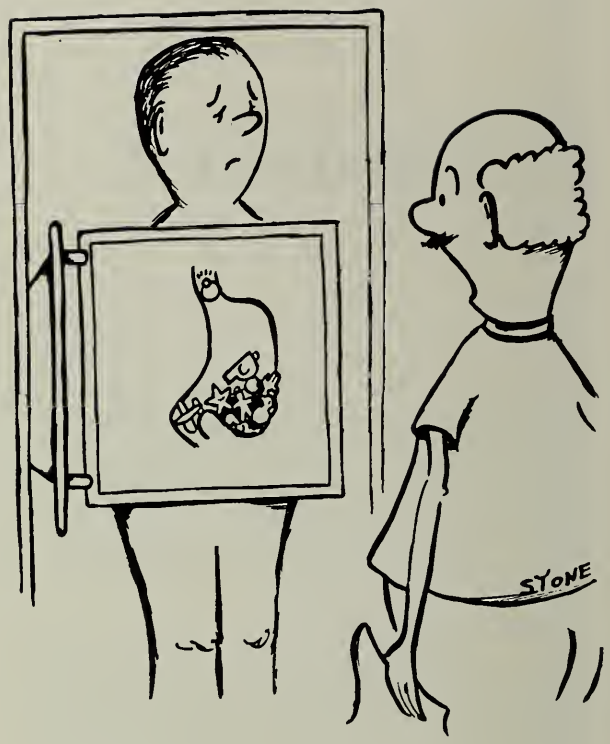
E.E.G. (Continued)

ted a crime or patients with rare but explosive forms of insanity who have also given way to acts of violence.

It is necessary to keep a sense of proportion about the meaning of these findings. One has to remember that these are only percentages of abnormality within a group. One-quarter even of the motiveless murderers had perfectly normal E.E.G. records. But nevertheless the tendency to commit an apparently motiveless act of extreme violence, explosively and unpredictably, does seem to be linked with a particular kind of instability and immaturity of brain function that can be recognized objectively and recorded. *David Stafford-Clark, M.D. The Foundations of Research in Psychiatry. Brit. M.J. Dec. 5, 1959.*

Elder-sitting

The genius of the younger generation in creating a system of baby-sitting to take care of the kids by proxy ought to be employed to do as much for their elders on occasion. It might be better than getting them out of the house permanently. *E. M. Bluestone, M.D. From the Consultant's Notebook. Hospital Management Aug. 1959.*



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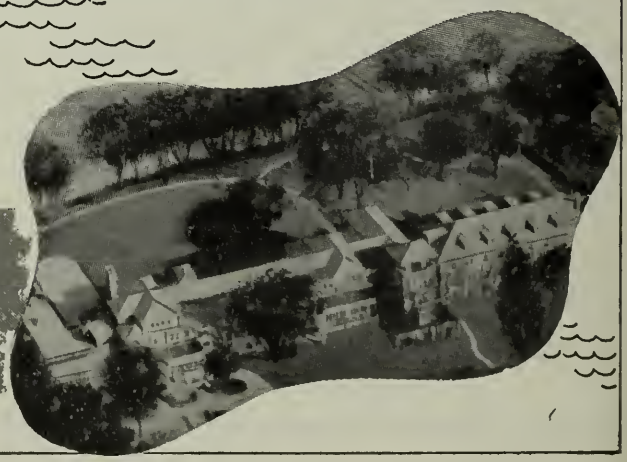
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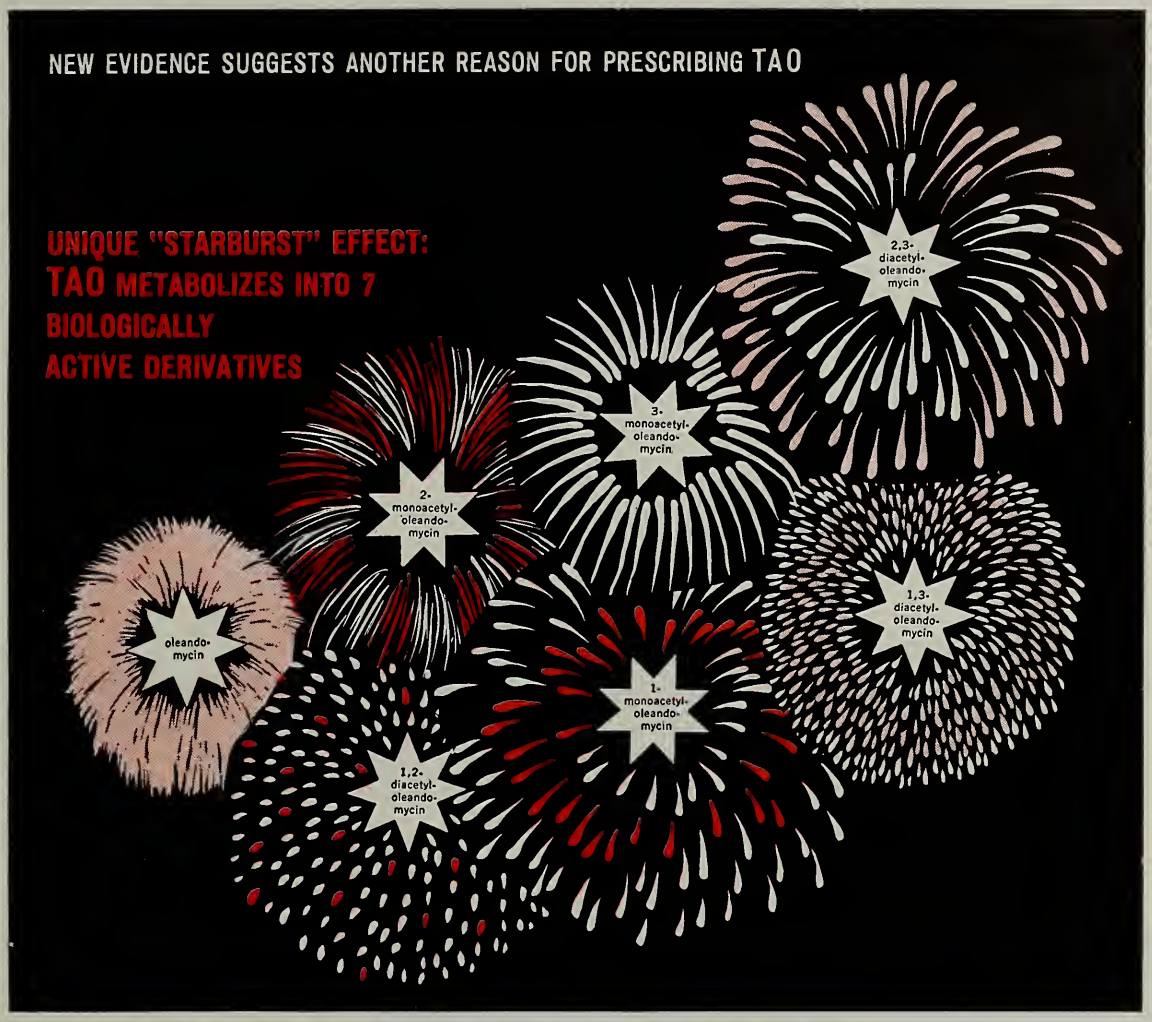
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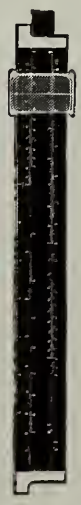
1. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. 100:880 (Apr.) 1959. 2. Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277. 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.

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It is becoming increasingly evident that some of the failures in cancer surgery are due to accidental seeding of cancer in the operative field. From the Spokane area, five cases of recurrence in the abdominal incision have been presented. It is suggested that increased attention be paid to the local contagion of cancer. Local recurrences may be reduced by preoperative surface sterilization of tumor where applicable, by scrupulous local quarantine of the cancer, by treatment of the fomites of the operating table with resterilization or with one-half strength Dakin's solution, and by treatment of the operative area with Clorpactin. *John Sonneland, M.D. Accidental Seeding of Cancer in the Operative Area. Northwest Med. Dec. 1959.*

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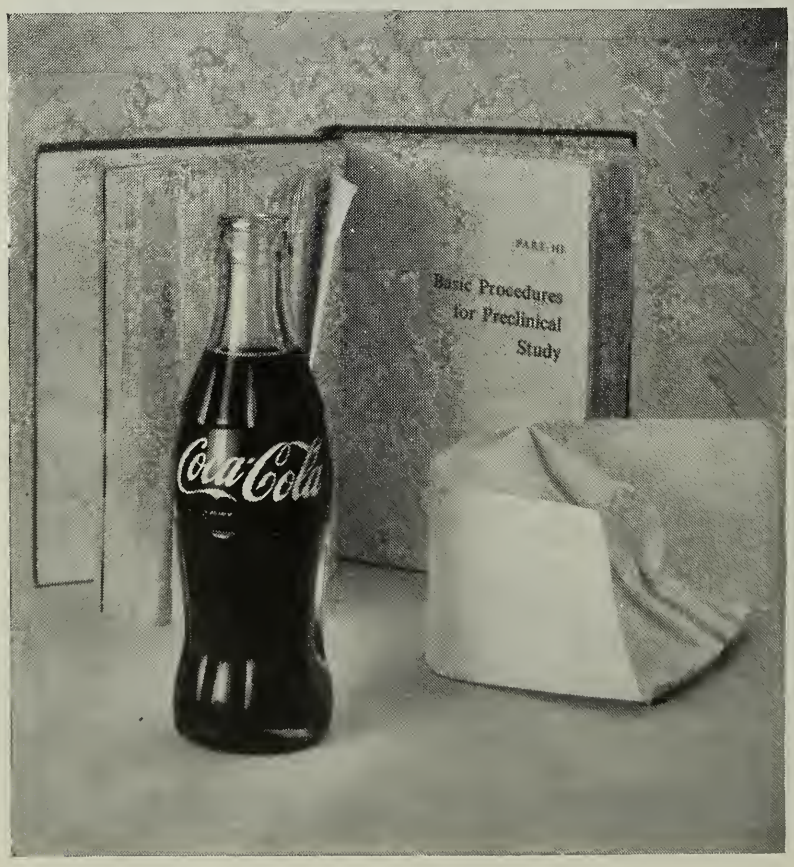
Medical economies

From the data obtained a general theory of national expenditure on medical care has been postulated. This theory states that the proportion of the gross national product a nation devotes to medical care tends to remain constant. It rises during national economic depressions and falls during wars. A persistent rise in real per capita gross national product tends to increase the proportion gradually. This theory appears to be applicable not only to the U.S.A. but also to other nations with a similar economic system. Difficulties that may occur in a democracy if the central authorities rapidly alter the relationship are considered. *J. R. Seale, M.D. A General Theory of National Expenditure on Medical Care. Lancet Oct. 10, 1959.*

‹ ›

An old approach

I have found that the elimination of foci of infection has resulted in permanent remissions from symptoms of vertigo, nausea, and vomiting and a reduction of tinnitus, together with sometimes even partial (minimum) recovery of hearing loss. Symptoms may recur only when another focus of infection appears or becomes active. *Joseph I. Kemler, M.D. Meniere's Disease. Maryland M.J. Oct. 1959.*



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An exaggeration and then some

There is surely no need to review the vast amount of experimental data that show how important hunger, thirst, and sexual drives are in behavior. It might be argued that these drives are for the most part so easily satisfied in modern urban civilization as to play a role far inferior to the need to avoid anxiety; the last, according to this reasoning, thereby becomes the primary motive force in civilized living. However, the present author is convinced, on the basis of his own introspections, supported by observations on man and other mammals, that boredom — or the need to avoid it — is the chief factor underlying activity under ordinary conditions of domestication, and that other drives take command in other circumstances. The idea that boredom is a potent motivating force has been emphasized in countless novels and plays. The idea has also been discussed by philosophers. For example, Kierkegaard, with typical exaggeration, wrote: "Adam was bored alone, then Adam and Eve were bored together; than Adam and Eve and Cain and Abel were bored en famille; then the population of the world increased and people were bored en masse. To divert themselves they conceived the idea of constructing a tower high enough to reach the heavens. The idea itself is as boring as the tower was high, and constitutes a terrible proof of how boredom had gained the upper hand." The corrosive effect of boredom was emphasized by Sir Horace Vere who replied to a question concerning the cause of his brother's death, "He died of having nothing to do." *Mark D. Altschule, M. D. Invalidity of the Diagnosis, Anxiety Neurosis. New York J. Med. Oct. 15, 1959.*

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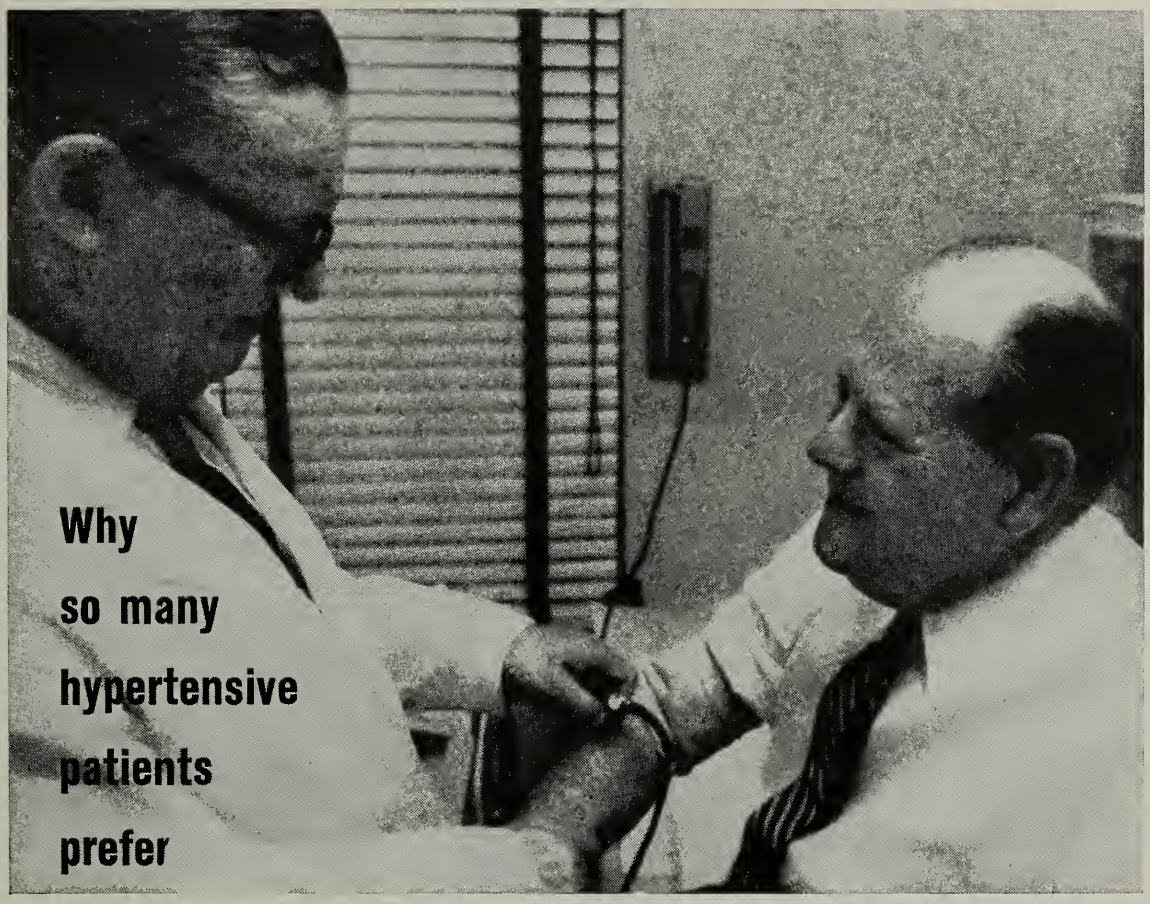
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*Herrmann, G. R., Vogelpohl, E. B., Hejtmancik, M. R., and Wright, J. C.: J.A.M.A. **169**:1609 (April 4) 1959.

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Quinacrine hydrochloride is the least used of the antimalarial drugs because of its toxicity, and chloroquine phosphate is possibly the most widely used although hydroxychloroquine sulfate and amodiaquin hydrochloride probably are of equal value. The choice of drug depends essentially on the tolerance of the patient to the individual drug and its effectiveness. Each patient does not necessarily respond to all members of the group.

The mechanism of the anti-inflammatory action is unknown. It apparently is not a simple light-screening mechanism. *Franklin S. Glickman, M.D., Harry Shatin, M.D., and Orlando Canizares, M.D. Antimalarial Preparations in the Treatment of Cutaneous Disorders. New York J. Med. Nov. 1, 1959.*

‹ ›

Basic scientific work

Speaking at a seminar held by the Pharmaceutical Advertising Club of New York on October 5, Dr. George W. Dana, administrator of North Shore Hospital in Manhasset, New York, stated "In the first half of the century, and indeed, until midcentury, the preponderance of basic scientific work stemmed from the academic centers." He pointed out, however, that since that time, "The balance has been swinging and will continue to swing to the [pharmaceutical] industry, for it is now apparent that from here on out there will be increasingly important leadership in the originality of ideas and their development from the industry." According to the Health News Institute, the pharmaceutical industry introduced to the medical profession more than 350 new products last year. *Health News Institute, Oct. 30 1959.*

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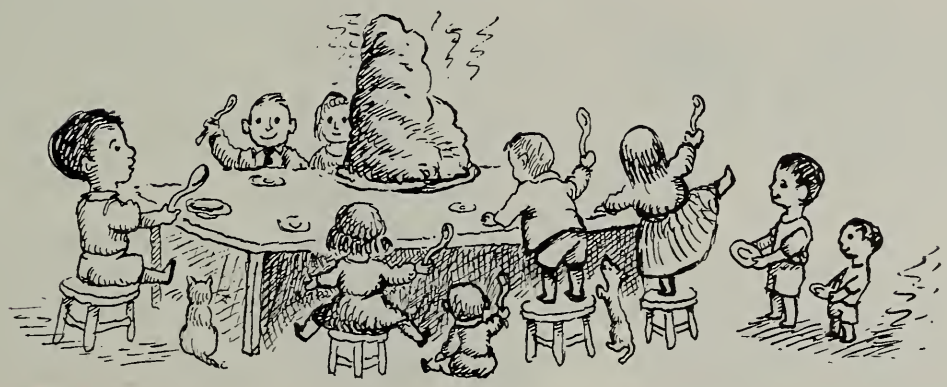
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In reviewing the work of practically every investigator of the past two decades it is apparent that, regardless of the operative procedure designed to bring in an outside blood supply to the heart, all have been of benefit. This also is apparent in the sham operation as performed by Beck and Leighninger. Only one conclusion can be arrived at—namely, the heart is an organ of such nature that it responds to any direct trauma by the development of intercoronary communications of appreciable size. In this regard it is interesting to note also that Zoll and associates found noticeable intercoronary communications in only 9 per cent of normal hearts and well developed intercoronary channels in nearly 100 per cent of cases where the myocardium had been traumatized previously by a coronary occlusion. It is believed that the irritant action of talc or the de-epicardialization with 95 per cent phenol serves as adequate trauma without undue risk to the patient. When this trauma is combined with vascular tissue apposition, internal mammary artery litigation, and sympathectomy, an operative procedure providing the maximum surgical benefit to the greatest number of cases of coronary insufficiency is developed. *Benedict R. Walske, M.D. The Surgical Treatment of Coronary Insufficiency. Nebraska N.J. Oct.* 1959.

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Volunteer Service Photographers, Inc., was organized in 1941, when the members photographed servicemen at canteens for their families. As wounded servicemen returned, the group began taking cameras and darkroom equipment to VA hospitals. Recognizing the therapeutic value of photography, the military surgeons general authorized VSP to teach rehabilitation photography. The organization has since grown to meet service requests from civilian hospitals in six states. VSP-trained volunteers, who share a love of photography, include housewives, dentists, and secretaries as well as professional photographers. VSP, with headquarters at 111 West 57 St., New York, is always interested in training additional volunteers. *Rehabilitation Through Photography. Hospitals Oct. 16, 1959.*

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(1) Barnes, R. H.: J.A.M.A. *166*:898, 1958. (2) Ressler, C.: J.A.M.A. *165*:135, 1957. (3) Birnberg, C. H., and Abitbol, M. M.: Obst. & Gynec. *11*:463, 1958. (4) Robillard, R.: Canad. M.A.J. *76*:938, 1957.

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Too many teachers are tape recorders

I think all of us in universities have been guilty in giving the public — even our trustees and strongest supporters — the mistaken impression that the progress of our institutions can be measured by counting the numbers of students taught, degrees granted, and the success of our alumni. These are facts that can be tabulated and measured and, in this era of expanding interest in higher education, look particularly good on graphs, for the line goes ever upward.

But it is my conviction that an institution that specializes in the regurgitation of information on an annual basis, even with both quantitative and qualitative success as demonstrated by instructional charts, cannot rightfully claim the status of a university, and that the faculty member who repeats only what he has learned from others is no better than a $100 tape recorder as a teacher.

A great university, in my estimation, is one that puts as much emphasis on expanding knowledge as it does on holding and transmitting knowledge. And a great faculty member is one who, in addition to his contribution to the teaching program, is making a real contribution to knowledge. *Conrad A. Elvehjem, Ph.D. Science and Medicine. Quart. Bull. Northwestern Univ. M. School, Winter 1959.*

‹ ›

Less support for TB

Federal support for work on tuberculosis is rapidly drying up. The main voluntary agency in this field contributes less than three per cent of its funds to research. A survey of contemplated and presently going research projects shows that many investigators are turning to nontuberculous respiratory disease and other fields. Unless some action is taken to provide support for research in tuberculosis we will fall short of the goal of complete conquest and understanding of this disease. We will have settled for less than the best, which seems to be an insidious disease in America today. *William S. Spicer, Jr., M.D. Research in Tuberculosis. Maryland M.J. Oct. 1959.*

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The Month in Washington



Congress appears headed for a showdown this session on legislation for the federal government to provide medical care for aged persons.

The medical profession and allied groups have stepped up their activities in opposition to such legislation as indications mounted that the issue was approaching a crucial stage. Several state medical societies plan to send delegations to Washington to express their opposition to their Congressmen.

Pressure behind such legislation began to build up early in February.

The Eisenhower administration announced it was working on three possible programs for providing health care for aged persons in cases of catastrophic — lengthy and costly — illness. Without amplification, President Eisenhower told a news conference that there was under consideration "a possible change" in the Social Security Act "to run up the taxes by a quarter of a per cent to . . . make greater provision for the care of the aged." The President's statement that "there has been no conclusion reached in the administration" was backed up by Arthur S. Flemming, secretary of Health, Education and Welfare, in a clarifying announcement.

Flemming said his department was working on two other approaches to what he called a serious problem in addition to the possible revision of the Social Security law mentioned by Mr. Eisenhower. The HEW secretary said consideration also was being given to: (1) stepped-up federal assistance under the federal-state public assistance program, and (2) the federal government supplementary voluntary insurance programs.

Flemming again expressed opposition to the Forand Bill, which would increase social security taxes by one quarter of one per cent each on employers and employes to provide hospitalization, surgical benefits, and nursing home care for Social Security beneficiaries. The secretary said he wanted to "underline that the position of the administration is opposition to the Forand Bill."

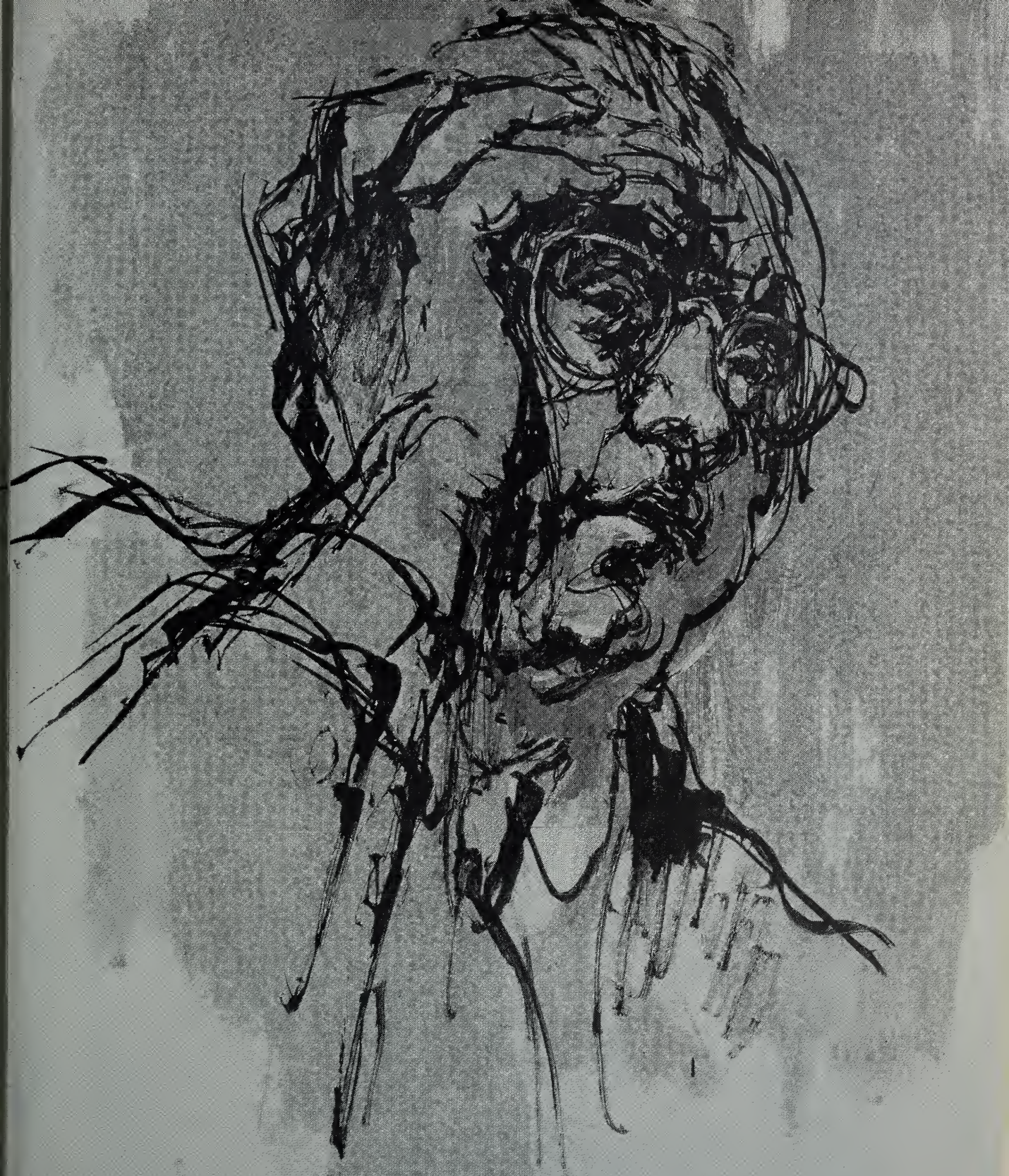
He said he hoped to have an administration bill ready to submit early in April to the House Ways and Means Committee, where the Forand Bill is pending. The committee is scheduled to take up in late March or early April proposed changes to the Social Security Act.

Proponents of the Forand Bill were pointing their campaign toward securing the House committee's approval of the legislation at that time.

The AFL-CIO, a main supporter of the Forand Bill, urged labor union members to write to congressmen on the committee urging them to vote for it. The AFL-CIO also distributed a pamphlet quoting a handful of physicians as supporting the legislation. But the labor organization didn't mention that the overwhelming majority of doctors oppose it.

The Senate Subcommittee on Problems of the Aged and Aging, headed by Sen. Pat McNamara (D., Mich.), issued on behalf of its Democratic majority a report stating that use of the Social

(*Continued on page 26*)



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WASHINGTON (Continued)
Security program "is the most efficient procedure for providing" health care for older persons.

The AMA and the subcommittee's Republican minority promptly disputed this conclusion. An AMA statement issued in Chicago said: "The American Medical Association today sharply disagreed with the recommendation of the McNamara subcommittee regarding government medicine for Social Security beneficiaries." Dr. Louis M. Orr, Orlando, Fla., president of the AMA, said: "This is a politically inspired committee. Senator McNamara . . . . has long supported political medicine. The fact is that, at the seven subcommittee hearings held throughout the United States, observers heard little support expressed by the older citizens who attended the hearings for government medicine financed by additional taxes and administered through Social Security."

The Republican minority stated that testimony before the Subcommittee "proves that it is possible for elderly people to secure private insurance to provide hospitalization and surgical benefits without any intervention by public authorities."

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, introduced legislation similar to the controversial Forand Bill but broader in scope. The Kennedy bill would eliminate surgical benefits but would add diagnostic outpatient and home nursing services.

Pennywise

One of the most memorable French exercises I was ever made to perform — I must have been 9 or 10 at the time — was to translate into French a little anecdote which ran thus: "A lady called upon a doctor to examine a spot on her finger. 'It is a very good thing you lost no time,' he said. 'Why? Is it so very serious?' she asked. 'Had you waited until tomorrow, it would have disappeared,' he said, 'and I should have lost my fee.'" *George Day, M.D. The Tardy Convalescent. Brit Med J. May 2, 1959.*



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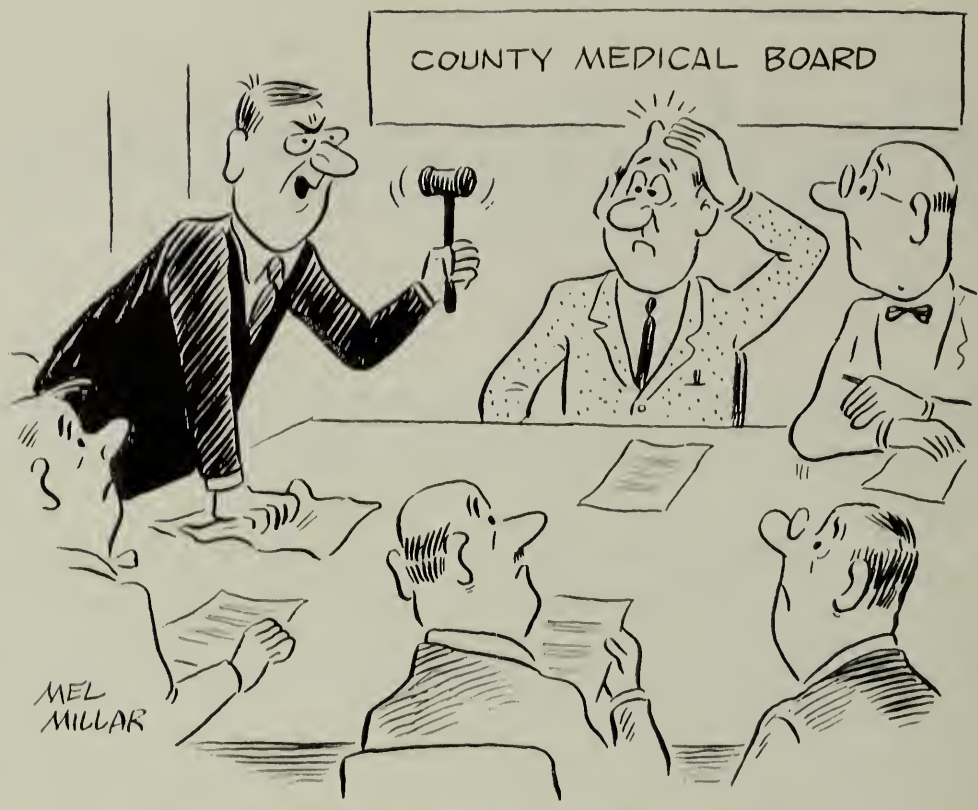
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1. A. M. A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

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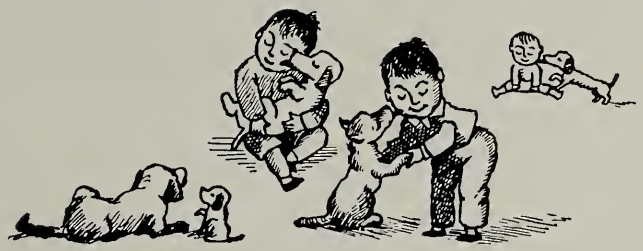
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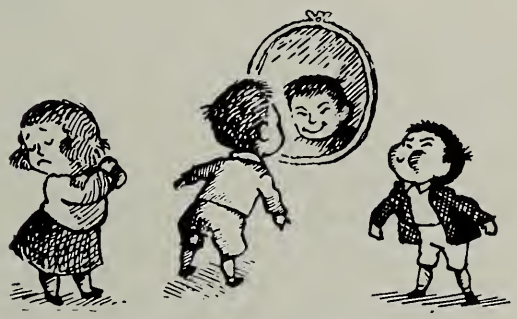
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dogs are to kiss people



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Magnuson—on fees

My theory on fees was and is that a person coming to a doctor to be cured of a disability is not like a woman going to the store to buy a silk dress. The woman doesn't have to have the silk dress; she can manage with a cotton one or the one she has on. But the patient does have to have the operation in order to get back as a useful member of society; and whereas the store can refuse to sell the dress to the customer if she does not have the money to pay for it, the doctor cannot refuse to perform the operation. There is no such thing as the medical equivalent of a cotton dress anyhow. The operation the doctor does on the pauper for no charge is the same operation — exactly the same, involving the same amount of preparation, the same instruments, equipment, and drugs, the same careful procedures — as the one he does on the man or woman of great wealth.

When you get right down to it, what the doctor is selling is literally and completely priceless. There is no use in his trying to put a price tag on it. So the fairest thing is to charge what the patient can afford to pay. *Paul B. Magnuson, M.D. Ring the Night Bell. Boston, Little, Brown and Company, 1960.*



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The
ILLINOIS
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Official Journal of The Illinois State Medical Society

MARCH, 1960
VOL. 117, No. 3

Tinea Capitis

Irene Neuhauser, M.D., Chicago

Tinea capitis, or ringworm infection of the scalp, is seen much more commonly in children than in adolescents or adults. It is caused by fungi belonging to a group known as dermatophytes. The dermatophytes are keratinophilic organisms that carry on their pathogenic activities in the keratin-containing tissues of the body—namely, the skin, hair, and nails. The organisms of this group that cause ringworm infections of the scalp belong to two genera: the Microsporum and the Trichophyton. They produce, roughly speaking, two types of clinical ringworm: the noninflammatory, or human type, to which man is the principal host and the inflammatory, or animal type that is transmitted to man only sporadically.

The predominant causative organism varies considerably with the geographic location but in this area, tinea capitis is most commonly associated with the microsporum group.

Clinical Associate Professor of Dermatology, University of Illinois College of Medicine.

Presented in part before The Section on Dermatology, Annual Meeting, Illinois State Medical Society, May 22, 1958. Additional material, principally on the use of griseofulvin in therapy, has been included through the courtesy of the Editor.

The epidemic type of tinea capitis is caused by Microsporum audouini. Prior to 1942-3 the disease occurred endemically in urban areas and in places such as orphanages, where numbers of children were permanently congregated. But at that time a nation-wide epidemic occurred. The infection begins as a small scaling spot or a small papule pierced by a hair and spreads peripherally, forming round or oval, slightly scaling patches of pseudoalopecia in which the hairs are broken off 2-3 mm. from the surface of the skin. This infection, known as gray patch ringworm, usually is noninflammatory and shows little tendency to spontaneous involution.

Microsporum canis and Microsporum gypseum, the other members of this group, produce acute inflammatory lesions in contrast to the low grade scaling lesions of Microsporum audouini. Microsporum canis produces ringworm infection in animals and is transmitted to man occasionally. Microsporum gypseum, rare in this area, lives as a saprophyte in the soil and is transmitted from that source. The deep inflammatory reaction, known as kerion Celsi, produces painful, boggy, ulcerative areas exuding pus.

Diagnosis of tinea capitis produced by the Microsporum group is confirmed by the greenish

fluorescence of the infected hairs under Wood's light, by the microscopic appearance of the hairs in potassium hydroxide solution, and by the cultural characteristics. In very early infections by Microsporum audouini and Microsporum canis, the infected hairs may not fluoresce and hairs infected with Microsporum gypseum rarely fluoresce. The Microsporum has an ectothrix arrangement of the small spores in a sheath surrounding the hair shaft and each has a characteristic appearance in culture.

Unlike the Microsporum group, the Trichophytons cause ringworm infections in adults and adolescents as well as in children. Whereas Microsporum audouini is the cause of epidemic ringworm of the scalp in the United States, Trichophyton tonsurans is the predominant cause of tinea capitis in Mexico and Puerto Rico. Over 90 per cent of tinea capitis infections in Mexico are caused by Trichophyton tonsurans and about 50 per cent of those in Puerto Rico. Endemic areas have developed in the southwest and the infection is increasing gradually in all parts of the United States, a condition causing some concern to public health authorities.

The members of the Trichophyton group produce a variety of clinical pictures. Those transmitted to man from animals, T. mentagrophytes and T. verrucosum, cause acute inflammatory ringworm with extensive kerion formation. They must be differentiated from such diseases as bacterial folliculitis, impetigo, and folliculitis decalvans by finding the fungi on microscopic examination of the infected hairs. Involvement of the hair is of the ectothrix type and must be further identified by cultural methods.

The human species of this group T. tonsurans, T. violaceum, and T. schoenleini cause chronic infections that may persist for years. They must be differentiated from such chronic diseases as psoriasis, seborrheic dermatitis, bacterial folliculitis, cicatricial alopecia, and lupus erythematosus. Hairs infected by members of this group do not fluoresce under Wood's light and diagnosis must be made by microscopic examination of the hair or by culture. Infection is of the endothrix type, with hyphae and spores invading the body of the hair.

T. tonsurans and T. violaceum infections result in so-called black dot ringworm. The dots are produced by the hair stubs that remain when the hair breaks off at the surface of the scalp. Infections by T. schoenleini produce yellowish, cup-shaped, elevated crusts called scutula that are characteristic of this infection.

The classical treatment of tinea capitis consists of topical medication and removal of infected hairs. Inflammatory ringworm, regardless of the causative organism, is a self-limiting disease since spontaneous epilation follows the inflammatory reaction.

If inflammation is slight, any therapy, such as Whitfield's or Anthralin® ointment may be used that will enhance inflammation. In a slightly more pronounced inflammation use a mild topical fungicide, such as 5 per cent ammoniated mercury or 2-3 per cent sulfur and salicylic acid ointment. In the acute form with kerion formation, topical fungicides are contraindicated; use only the mildest forms of therapy such as warm compresses of Burow's or boric acid solution. If secondary infection occurs, appropriate and systemic antibiotic therapy should be used. In severe cases, scarring and permanent alopecia may occur.

In noninflammatory infections, removal of the hair is best accomplished by X-ray epilation. In Microsporum audouini infections, prophylactic and curative measures should be tried first.

1. The hair should be clipped short to facilitate the application of the medication.
2. The infected hairs should be epilated manually once weekly.
3. The scalp should be shampooed frequently, preferably every day.
4. A snugly fitting cap should be worn at all times and the cap should be sterilized frequently by boiling.
5. Topical fungicides such as those containing fatty acids or salicylanilid should be applied twice daily. These preparations are on the market under such trade names as, Salundek®, Salinidol®, and Decupryl®.
6. Topical fungicides should be changed every four to six weeks because the organisms seem to develop resistance to any particular medication.

Tinea capitis caused by the endothrix type of organisms rarely responds to topical therapy other than X-ray epilation. Adults should be given larger doses than children and a rigid follow-up is necessary. The patient should be seen frequently for the manual removal of any hairs that do not loosen as a result of X-ray therapy.

The limitations of the classical, topical therapeutic measures in the treatment of tinea capitis and, in fact, of all the dermatomycoses have long been recognized. It was a milestone in the advancement of dermatologic therapy when, in 1958, the antibiotic griseofulvin, isolated in 1939 from Penicillium griseofulvum, was reported to be active systemically in human subjects against a variety of fungal infections of the skin, hair, and nails. Subsequently, the rapidly expanding clinical literature on griseofulvin has amply confirmed and extended the original observations and it is now accepted as the drug of choice in the treatment of superficial fungal infections caused by the dermatophytes.

The exact mechanism by which griseofulvin is effective when taken orally is not completely understood. It is absorbed from the gastrointestinal tract and is believed to be subsequently deposited and incorporated in the keratinous tissues of the skin, hair follicles, and nails. Here it acts fungistatically, inhibiting the growth and reproduction of the organisms. As the inactivated organisms are eliminated gradually, healing of the lesion progresses and is finally complete.

Excellent results have been reported in tinea capitis, improvement being quite apparent by the third week of treatment. Healing of the lesions and disappearance of the infecting organism usually are observed by the end of the fifth week.

Following the oral administration of griseofulvin the infected portion of the hair is replaced gradually by normal hair. By the end of the fourth or fifth week, the hair should be clipped rather short to remove its infected portion, thus avoiding recurrence or spreading of the disease.

Although the exact minimal dosage has not been established, a daily divided dose of 500 mg. for children and 1,000 mg. for adults over a period of four to five weeks has proved to be curative.

Griseofulvin has a low toxicity and usually is well tolerated in the recommended dosage. A few mild, self-limited side effects have been reported such as gastric discomfort, diarrhea, and headache. An occasional patient may develop urticaria or a cutaneous eruption in which case therapy should be discontinued and the older classical treatment instituted. In a few patients a moderate decrease in the white cell count, reversed on withdrawal of the drug, has been reported. For this reason a blood count should be included as part of the patient's regular examination at appropriate intervals while receiving griseofulvin therapy.

REFERENCES

Conant, N. F.; Smith, D. T.; Baker, R. D.; Callaway, J. L.; and Martin, D. S.: Manual of Clinical Mycology, Philadelphia, 1954, W. B. Saunders Company.

Pipkin, J. L.: Tinea Capitis in the Adult and Adolescent, A.M.A. Arch. Dermat. & Syph. 66:9, 1952.

Carrion, A. L., and Silva, M.: Ringworm of the Scalp in Puerto Rico, Puerto Rico J. Pub. Health & Trop. Med. 19: 329, 1944.

Gonzalez Ochoa, A., and Romo Vazquez, B.: Dermatofitos cauantes de tenia de la piel cabelluda en la ciudad de Mexico, Rev. Inst. salub. y enferm. trop. 6:145, 1945.

Georg, L. K.: Trichophyton Tonsurans Ringworm—A New Public Health Problem, Pub. Health Rep. 67:53, 1952.

Mullins, J. F.: Trichophyton Tonsurans Infection in Tinea Capitis Survey, A.M.A. Arch. Dermat. & Syph. 69:438, 1954.

Wilson, J. Walter, M.D.: Clinical and Immunologic Aspects of Fungous Diseases. 1957, Charles C. Thomas, Springfield, Illinois.

Conant, N. F.: Fungous Infections of the Hair and Nails, J. Chronic Diseases, 5:506-517, May 1957.

Gentles, J. C.: Experimental Ringworm in Guinea Pigs: Oral treatment with Griseofulvin, Nature, London 182:476 (Aug. 16) 1958.

Blank, H.: The Use of a New Anitbiotic in the Treatment of Fungous Infections, presented at the 17th Ann. Meet., Am. Acad. Dermat. & Syph., Chicago, Dec. 6-11, 1958.

Blank, H., and Roth, F. J., Jr.: The Treatment of Dermatomycoses with Orally Administered Griseofulvin, A.M.A. Arch. Dermat. 79:259 [March] 1959.

Problems of Venereal Disease Control in the U.S.S.R.

Leon M. Beilin, M.D., Chicago

One of the major achievements of Soviet medicine and the public health program of the U.S.S.R. has been the organization of venereal disease control, with the prospect of imminent liquidation of primary and early congenital syphilis and drastic reduction in the incidence of gonorrhea.

In Czarist Russia, there was no effective planned V.D. control, although this was a major public health problem along with typhoid fever, tuberculosis, and alcoholism.

After the October Revolution of 1917, planned control of V.D. was started on a mass scale. During the first years of the Soviet regime, so-called expeditions were organized and sent to the provinces for demographic studies, gathering of epidemiologic data, and to establish a centralized registry for V.D.[1] The People's Commissariat of Health sent demonstration teams to establish centers for the survey and mass treatment and to train physicians and auxiliary staff in modern methods of treatment and control of V.D. This was followed by organization of a ramified network of urban and rural dispensaries and clinics with laboratory facilities for mass serologic screening, especially of pregnant women, who were required to show prenatal health certificates in order to benefit from the State grants to mothers.[2]

By the end of the second five-year plan, more than one thousand such expeditions and teams had been organized and sent to the rural districts, while the number of V.D. clinics steadily grew. By 1955, according to official registration, their number had reached 5,587.[3] V.D. patients are treated in these clinics, when ambulatory, and are hospitalized during the acute or infectious stages of the disease.

Thus, a patient with a fresh case of syphilis is hospitalized within 24 hours, for a period of six weeks — the duration of the first course of treatment. Those with acute gonorrhea or g.c. carriers, especially women, are isolated and hospitalized, primarily as a quarantine measure, if the beds are available.

The number of available hospital beds for the treatment of V.D. patients has steadily increased from 14,365 in 1940 to 27,675 in 1955.[4] In addition, close co-operation between venereology and general medicine is effected through organization of V.D. departments in all general hospitals.

The district clinics attempt to adjust the treatment to the needs of the individual patient. Thus, taking into account that in the villages or on collective farms, it often is difficult for the patient to visit the clinic several times a week for regular injections of antibiotics, salvarsan, or heavy metals, larger doses of these drugs are administered simultaneously once per week or at five to six day intervals. Patients who live in distant villages are visited by special teams of venereologists and sanitary workers for on-the-spot treatment.[5] Soviet physicians apparently do not share our enthusiasm for penicillin, and are unwilling to trust to its use alone the treatment of syphilis.

In Russia, as in most European countries, venereology and dermatology comprise a single medical discipline, that of dermato-venereology, and dispensaries cope simultaneously with V.D. and skin diseases, especially those of social significance, such as fungal infections, urticaria, pyoderma, tuberculosis of the skin, and industrial dermatoses. There were 4,260 registered full time dermato-venereologists on the government payrolls in 1940; 8,092 in 1950; and 8,524 in 1956.[6]

The Soviet Union has a very broad public health system. According to data published by the Secretariat of the U.N., there were 346,000

Read before North Central Section of the American Urological Association, Inc., Oct. 8, 1959.

registered physicians in the health service in the U.S.S.R. in 1957, the ratio of one to 600 of population.[7]

Wide use is made of the system of postgraduate medical study. After a clinician has worked five years in the field he is entitled and encouraged to attend a refresher course of four months, with full pay for the whole period of training, with defrayal of travel expense.[8]

A patient who applies for examination or treatment at a V.D. clinic usually is registered by his identification, such as passport, work certificate, or military tag. When found to have a venereal or any other infectious or communicable disease, he is issued a special health card on which are recorded the original diagnosis, the laboratory findings and serologic data, and a transcript of all treatment received to date and recommendations for any further treatment. The fact that he has been issued such a health card is noted on his identification. Each patient is required to carry this card on his person at all times, as a motorist in the U.S.A. carries his driver's license.

The so-called Venereal Disease Act of Article 150 of the Penal Code of the U.S.S.R., adopted in 1923, grants exceptionally wide powers to the Soviet physician, who, as an agent of the government, is authorized to initiate, organize, and enforce all measures of control and treatment of alleged sources, contacts, and carriers of infection. Any person who refuses to submit to examination or who defaults treatment or the follow-up until such time as he is deemed noninfectious by his physician is guilty of a misdemeanor and, in compliance with Articles 150 and 192 of the above Criminal Code, is subject to prosecution, fine, or forced labor.[9] Besides, the stigma of being antisocial, an obstructionist, or worse, is placed against the culprit. The Ministry of Health reports that in about 75 to 80 per cent of cases the sources and contacts are traced and brought to examination.[10]

It is of interest to note in this connection that penicillin is administered to all alleged female contacts or infective carriers even if gonococci were not demonstrated on examination.

The advent of sulfonamides, and later of penicillin, has dramatically changed the natural epidemiology of V.D. throughout the world. There can be little doubt that syphilis is disappearing as an important public health problem in the U.S.A. and elsewhere. However, the hope once held that antibiotics would prove a panacea for the control of V.D., no longer prevails. In fact, some recrudescence has been noted recently by the World Health Organization, which concludes that the outlook for the control of gonorrhea is now somewhat less favorable than it was a few years ago.[11]

The U.S. Public Health Service reports that for the first time since 1948, the total reported cases of V.D. increased in the fiscal year 1956. It estimates that the annual infection with syphilis in this country is about 125,000 and that of gonorrhea, in excess of one million.[12] The Chicago Board of Health reported 19,313 cases of acute gonorrhea for 1958, a ratio of 501.6 per 100,000 of population, and that of syphilis (all forms) 5,759, a ratio of 149.5 per 100,000. There were 204 primary cases.[13]

By contrast, the latest official figures of the Ministry of Public Health of the U.S.S.R. for 1956 gave the incidence of syphilis as about 10 per 100,000 of population. It reports further that the number of freshly acquired cases of syphilis was so small, in many sections of the country not a single case was registered during the whole year. Early congenital syphilis is disappearing rapidly, none being reported in recent years in many large sections of the country.[14] Obviously, how many of these figures are facts, fancies, or propaganda is a matter for conjecture.

It is axiomatic that sexual habits of people change but slowly and they stubbornly defy imposed moral laws, rules, or regimentation, no matter how stringent they may be. Manifestly, it would be an error to credit any success achieved in the control of V.D. in the U.S.S.R. solely to the efforts of Soviet medicine or to the repressive measures of a totalitarian state. While Soviet medicine must get full credit for its achievement in the field of public health in the short span of 40 years, a record — as it has been suggested — without parallel in medical annals, this could be done only in a social system where the interests of the state and of the group transcend those of the individual, and where the layman no less than the physician is subordinate to the state.

However, viewed in total context, the major contributing factors of this achievement were general improvement in cultural, socioeconomic, and educational status of the people, liquidation

of unemployment, better housing, equality of women socially and in the labor field, repression of prostitution, legalization of abortion, and nonrecognition of illegitimate births. Added to these factors was allocation of large state funds for protection of the health of the people, the budgetary appropriation for which for 1958 was in excess of 40 billion rubles.[15]

In the final analysis, the struggle to conquer age old, ubiquitous, venereal diseases is not solely a province of medicine but is a part of the broad social spectrum.

185 North Wabash Avenue

REFERENCES

1. Kozhewnikov, Pyotr V.: Organization of Syphilis Control in Soviet Union, Brit. J. Ven. Dis. 32:231-233 (Dec. 1956.
2. ibid.
3. Studnitzin, A. A., and Turanov, N. M.: Results of the Combat with Venereal and Contagious Skin Diseases in the U.S.S.R., Vestnik Derm. i Vener. 5:3-11 1957.
4. ibid.
5. Reference #1.
6. Rosentul, M. A.: Achievements in Soviet Syphilology in 40 years, Vestnik Derm. i Vener. 5:22-29 1957.
7. United Nations, Secretariat, Dept. of Public Information 1958.
8. Reference #1.
9. Mokotchenko, M. M.: On Anivenereal Law and its Practical Application, Vestnik Derm. i Vener. 3:52-55 1958.
10. Frankel, B. L.:Achievements of Ukrainian Dermato-Venerologic Organization in Venereal Disease Control, Vestnik Derm. i Vener. 5:28-31, 1958.
11. World Health Organization, Ven. Dis. Survey of Existing Legislation p. 44 1956 (Geneva).
12. U.S. P.H.S. Fact Sheet, 1956.
13. Chicago Board of Health, unpublished data.
14. Bukalev, A.: The State on Guard of Public Health, Moscow, Foreign Language Publishing House, 1955, pp. 51-59.
15. ibid.

Reducing Fractures of the Nose With Urethral Sounds

Glenn E. Wright, M.D., Woodstock

THE technique herein described presents a simplified method for the reduction of fractures of the nose, commonly seen in the office of the surgeon and the general practitioner.

The patient is placed in a comfortable sitting position in a chair with a head rest, preferably one that can be tilted back. This is helpful should the patient become faint, and the head rest can be elevated to a convenient working position for the physician.

Select a sterile urethral sound of the proper size to fit inside the patient's nose, manipulate it with one hand, and the nasal bones from the outside with the other hand, using the sound as a mold. Reduction ordinarily can be accomplished without anesthesia, except occasionally in children. Nasal fractures that are reduced properly usually maintain their position without splints or any other external or internal supports.

I have used this method for years with great satisfaction and many of my colleagues have adopted the method on my recommendation. It may be used in all fractures of the nose, with or without cartilage involvement.

SUMMARY

1. Results are good, cosmetically and functionally.

2. The technique is simple and may be done in the office.

3. Anesthesia and external splints ordinarily are not necessary.

Eustachian Tube and Middle Ear Therapy

G. C. Otrich, M.D., Belleville

THE Practical Handbook of Diseases of the Ear," by William Milligan, M.D. and Wyatt Wingrave, M.D., published in London in 1911, describes the passing of a Weber-Liel intratympanic tube. Many authors have discussed and described dilatation of the eustachian tube with bougies. However, we wish to present a revival of an old method of therapy, using present day medication through a small guided polyethylene tube.

The treatment as described is an office procedure for patients with infection in the middle ear in which there is a large perforation of the membrana tympani or in patients in which there is an intact membrana tympani. It is of value in treatment of patients who have had past infections or who have developed physiological changes in the structure of the middle ear; in adhesions in the course of the eustachian tube, in secretory otitis media, postsecretory otitis media with adhesions, tinnitus, and possibly for the treatment of otosclerosis.

The equipment needed for this procedure is listed as follows:

1. Eustachian catheter with bulbous tip, chrome plated with Luer taper, size No. 2.
2. Eustachian bougies of the whale bone type.
3. Polyethylene tubing, No. 90.
4. Twently gauge needle that has had the sharp point and bevel destroyed and has a rounded end.
5. Twenty per cent cocaine solution.
6. Aniline oil and glycerin, equal parts, with cocaine 10 per cent.
7. A glass straw in which to store the polyethylene tubing.
8. Snare wire that will fit in the No. 90 polyethylene tubing.

This paper was read and demonstration of procedure given at the meeting of the Central Illinois Society of Ophthalmology and Otolaryngology — Sept. 20, 1958.

PRETREATMENT PREPARATION

1. The nose and the postnasal area are washed by inhalation with normal saline from a cup or a glass.
2. Application of 20 per cent cocaine to the eustachian orifice via the nose.
3. The whale bone eustachian bougie is inserted into the eustachian catheter so that the tip passes the bulbous end of the catheter. The tip of the bougie is dampened with the aniline oil solution and then withdrawn into the catheter. The eustachian catheter is placed properly in the mouth of the eustachian orifice, and the bougie is gently passed up into and through the eustachian tube. If strictures or resistance are encountered, the bougie is pushed forward gently and the strictures are dilated. If it is impossible to dilate with the bougie that is used, a smaller bougie should be tried. Larger bougies are then inserted until the size is reached that corresponds in size to the polyethylene tube. The first bougie which is passed is allowed to remain in the eustachian tube for 10 minutes, with the patient or an assistant holding it in place. The bougie is then removed. The eustachian catheter, however, is held in position and through it is passed a 10 inch polyethylene tube, No. 90, with a snare wire guide in it. This is passed up toward the middle ear. If it cannot be passed into the middle ear, it may be feasible to instill the medication at this time. Otherwise, the polyethylene tube is passed into the middle ear and the medication is instilled. It has been found that the bougies and the polyethylene tube are inserted about two or three centimeters past the end of the eustachian catheter tip. The steel guide is then removed from the polyethylene tube and the medication is instilled. As stated before, a 20 gauge needle has been inserted into the lumen of the polyethylene tube and this makes a proper connection for a 2 cc. syringe.



Roentgenogram showing small catheters extending from eustachian tubes to middle ear for therapy.

If the tube cannot be inserted into the middle ear, it has been found that the medication instilled at the place of obstruction often causes such a reaction or decreases resistance so that the bougie and the catheter can be passed into the middle ear at the next treatment.

The types of medication that have been instilled through this method are as follows: Hydrocortone®, Hydeltrasol®, and Neo-Hydeltrasol®.

In the case of infection with a large perforation of the membrana tympani, the routine as before mentioned is followed and the polyethylene tube is inserted into the middle ear. Three minims of Streptokinase® and Streptodornase® are inserted. Two cc. of air are inserted following this medication. Treatments can be repeated every four or five days for three or four times. Shortly after the administration of this medication, massive amounts of exudate begin to flow from the external canal of that ear. It has been found in many cases of chronic otitis media and subacute otitis media that the ear will dry up quickly and many times the perforation of the membrana tympani will close. In other cases, antibotics can be instilled in a like manner. In secretory otitis media, the same procedure is followed except that the metal guide that guides the polyethylene tubing into the middle ear is then forced forward through the middle ear and through the membrana tympani into the external canal. It has been found that this puncture (inside out if you will) has caused myringotomy on the inferior area of the drum of the membrana tympani and does not come near the ossicular chain.

The medication used in secretory otitis media is 4 minims of 25 mg. per cc. of Hydrocortone followed by 2 cc. of air to insure the medication's reaching the middle ear.

In conductive deafness, which we have described as tubal deafness, the same procedure is followed except that no myringotomy is performed. Hydrocortone is used and treatments are given twice a week, then every two weeks, the patient returning according to deafness, tinnitus, and recurrence of symptoms.

In vertigo of several weeks' duration, the same procedure is followed and if no relief is encountered in two or three treatments, it is discontinued. However, some cases of vertigo and tinnitus have improved after the second visit. This is still being investigated.

No complications have been observed in that there have been no toxic reactions and no infections induced by this procedure. However, after these treatments the patient often has severe vertigo lasting three to five minutes and deafness is increased for three or four days after a treatment.

DISCUSSION OF PROCEDURE

Among many otolaryngologists, there has been a fear that the whalebone bougie may break off and be lost in the eustachian tube. After many years of using these bougies and never having had such a mishap, I am not greatly concerned about it. I do not feel that we should be apprehensive about this possibility because there is a peristaltic action of the eustachian tube and its surrounding muscles. The bougie must be held in the eustachian tube when dilatation is being done and the patient is allowed to rest with the bougie in place. If the bougie is not held, it begins to come out of the eustachian tube by peristaltic action. I feel, therefore, that if a bougie tip is lost in the eustachian tube, that within a very short time it will be expelled into the postnasal vault. However, if the tip were broken and lost in the middle ear cavity, this would necessitate doing a procedure through the external auditory canal to reach it.

SUMMARY

A method is here presented for instilling medication into the middle ear via the eustachian tube. In 30 cases of various types of infection, tubal deafness, tinnitus, secretory otitis media, and adhesive otitis media, 25 cases have had definite improvement. Some of these cases have been followed for a period extending up to two years. In our hands, it has been safe.

The problem of otosclerosis has been treated in the past few years by surgery. If otosclerosis is arthritis of the ossicular chain, especially that of the foot plate of the stapes, why cannot the flooding of the middle ear with Hydrocortone absorb the arthritic process such as it does in joints and in other parts of the body and aid in hearing? These cases have not been followed with audiograms, but we hope that this paper will stimulate such a study.

Due to lack of space the table containing complete information on the 54 cases was omitted. A copy of this table can be obtained by writing to the author.

No miracle

Warts, unfortunately, despite a variety of methods used in their control, have persisted as a blemish on the human integument, and now the *Lancet,* like the English longbowmen at Crecy, has developed a surprise attack. Sinclair-Gieben and Chalmers, in a recent issue, admitting a degree of uncertainty in regard to the treatment of warts by hypnosis, because of the small number of cases so treated, the usual lack of controls, and the frequency of spontaneous recovery, proceed to report their own experience.

In a pilot study, 6 out of 7 patients were freed from their affliction within three months by means of medium deep hypnosis—the remaining, or odd, patient was mentally defective. They then instituted the main trial on 14 patients, all of whom had warts on both sides of the body. One side only was treated, the other side being left as a control; the hypnosis itself was bilateral, an adequate depth being reached in 10 cases. Nine cases were cured on the treated side and one also on the untreated side, possibly because of an excess of enthusiasm on the part of the subject. The one failure was with the only patient in whom posthypnotic suggestion was absent.

The results were less spectacular only than those obtained in the case of Adam, but the operator in the matter of Adam's rib was one from whom spectacular results may be expected. Since the etiology of warts is still in doubt, it cannot be said that Koch's postulates have been fulfilled, nor is there as yet any evidence that warts have been produced by hypnosis. *Editorial. Hypnosis Verrucae. New Engl. J. Med. Jan. 1960.*

Therapy of Iron Deficiency Anemia with Parenteral Iron-Dextran

Eugene F. Diamond, M.D., Chicago

Iron deficieney anemia is the most common hematologic disorder in infancy. It is seen most commonly as a result of inadequate iron stores resulting from iron deficiency in the mother or the late anemia of prematurity; inadequate iron intake (such as milk-drinker's anemia in the second year of life); and poor iron absorption.

Although this type of anemia ordinarily, is readily amenable to therapy with improved dietary iron intake and adequate oral medicinal iron, in certain instances parenteral iron is the preferred method of therapy. Indications for intramuscular iron-dextran therapy in this study are summarized in Table 1.

Table 1

Indications for parenteral iron therapy:

1.) Anemic infants with known histories of parental neglect.
2.) Anemic infants with intolerance for oral iron or malabsorption disorders.
3.) Anemic infants with heart disease — parenteral iron therapy avoids the transfusion hazard of high output failure from circulatory overload.
4.) Anemic infants being prepared for elective surgery.
5.) Infants with severe iron deficiency anemia and recurrent infections.
6.) Female infants with severe iron deficiency anemia — to avoid transfusion and the attendant risk of permanent isosensitization and future hemolytic disease in offspring.
7.) Uncooperative, recalcitrant children unwilling to take oral iron.

METHOD AND MATERIALS

Patients — A total of 22 infants ranging in age from 8 months to 24 months were treated in this study.

The patients were seen in private practice or in the pediatric clinic of the Merey Free Dispensary.

DIAGNOSIS

Two simple, reliable indices of iron deficiency were used for admission to the study:

1. Morphology of peripheral red blood cells — i.e. microcytosis and hypochromia characteristie of iron deficiency state.
2. Mean corpuscular hemoglobin concentration

   Calculation = Hemoglobin (gm./100 cc.) /Hematocrit (%) = MCHC (%)

   Normal = 32-36%

   Patients with MCHC = 30 or less were admitted to the study.

THERAPY

Intramuscular iron-dextran complex (Imferron®) containing 50 mg. elemental iron per cc. was the material used. The amount of medication to be used was determined by the formula: 0.3x wt (100-Hb%)/50 = dosage in cubic centimeters.

RESULTS

The results of this study were in agreement with the success of parenteral iron therapy by other investigators.[4,5,6,7] Hemoglobin and the hematocrit rose promptly. The response in patients with hemoglobin below 7 grams is shown in Figure 1. In severe anemia, there was a marked reticuloeyte response. Figure 2 shows a typical retieulocyte, hemoglobin, and hematocrit response in a patient with an initial hemoglobin of 4.0 gm. In general, the clinical improvement paralleled the hematologic improvement. A sum-

Assistant Clinical Professor of Pediatrics, Stritch School of Medicine of Loyola University.

*The Imferron used in this study was generously supplied by Lakeside Laboratories, Inc.

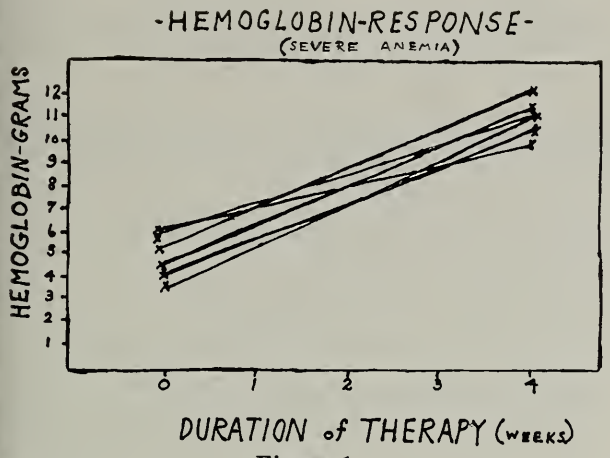


Figure 1

mary of data on the 22 patients treated is shown in Table 2.

The average hemoglobin rise in the entire group during therapy was 3.9 gm. The hemoglobin response was more dramatic in the severely ill infants.

Side effects were limited to discoloration of the subcutaneous tissues in three patients. This effect may be minimized by use of the Z - track method of injection. No systemic reactions were noted.

Table 2
Summary of Data on 22 Patients

	Age in months	Hb before Therapy gm. %	Hb after Therapy gm. %	Increment gm.	Increment weeks
1.)	22	3.5	11.0	7.5	4
2.)	21	4.0	10.5	6.5	3
3.)	19	4.0	11.0	7.0	4
4.)	10	5.0	12.0	7.0	4
5.)	24	5.0	10.5	5.5	4
6.)	14	5.5	10.2	4.7	4
7.)	13	5.7	9.5	3.8	3
8.)	8	6.0	11.0	5.0	4
9.)	20	6.5	10.0	3.5	3
10.)	12	6.7	9.2	2.5	3
11.)	18	7.0	10.5	3.5	4
12.)	8	7.0	11.0	4.0	5
13.)	21	7.3	10.8	3.5	4
14.)	16	7.5	9.5	2.0	3
15.)	11	8.0	11.2	3.2	4
16.)	24	8.0	10.2	2.2	4
17.)	18	8.5	11.2	2.7	4
18.)	12	8.5	11.5	3.0	4
19.)	16	9.0	11.0	2.0	3
20.)	22	9.0	11.2	2.2	4
21.)	20	9.0	11.5	2.5	3
22.)	24	9.5	12.0	2.5	4

SUMMARY

1. Twenty-two infants with iron deficiency anemia were treated with intramuscular iron-dextran complex.

2. Response was noted in each case by a

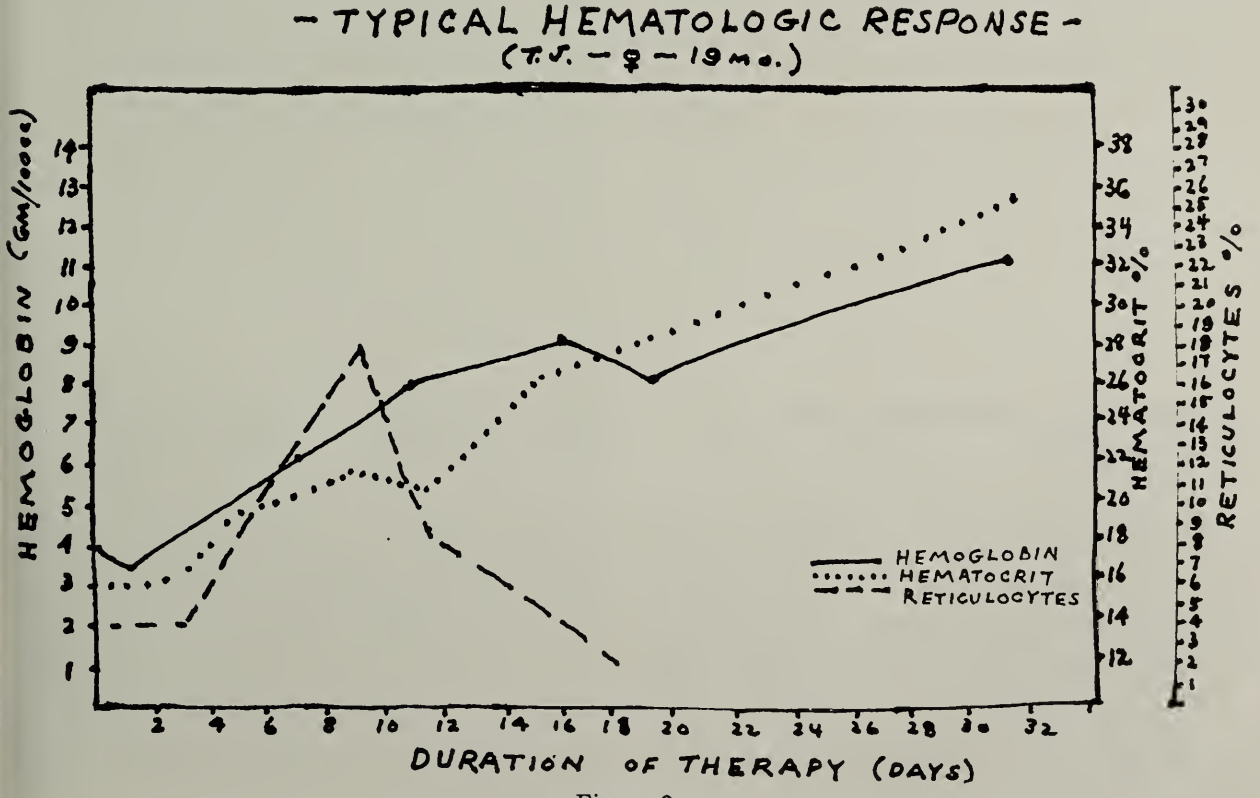


Figure 2

prompt rise in hemoglobin and hematocrit levels and by a reticulocyte response in severe anemias.

3. Complications were limited to transient local pain at the injection site and discoloration of the subcutaneous tissues in three cases. No systemic reactions were noted.
4. The indications for parenteral iron therapy in iron-deficiency anemia are listed. It is concluded that intramuscular iron-dextran complex offers a safe and effective mode of therapy for patients requiring parenteral iron.

11055 St. Louis Ave., Chicago, 43

Acknowledgements: Appreciation is expressed to Dr. John O'Shea, Dr. David Lee, and Dr. Lois Boswell, who assisted in the collection of cases.

REFERENCES

1. Diamond, L. K., et al: Nelson's Textbook of Pediatrics, W. B. Saunders Co. 1959.
2. Bowman, H. S., and Tursky, R. J.: Scientific Exhibit, American Academy of Pediatrics, Chicago, October, 1958.
3. Lichtman, H. C.: Current Status of Therapy of Anemias, J.A.M.A. 167:735, 1958.
4. Wallerstein, R. O.: Intramuscular Iron for the Treatment of Iron Deficiency, J. Pediat. 49:173, 1956.
5. Jennison, R. F.: Some Clinical Applications of Intramuscular Iron Therapy. Proc. Cong. Internat. Soc. Hemat. 1958
6. Sturgeon, P.: Studies of Iron Requirements in Infants and Children, Pediatrics 18:267, 1956.
7. Wallerstein, R. O., and Hoag, M. S.: Treatment with Iron-Dextran of Iron Deficiency Anemia in Children, J.A.M.A. 164:962, 1957.

Community education and preeclampsia

Although preventability of many of the obstetric deaths is ascribable to the physician, a considerable part of the responsibility lies with the patients themselves. They need to realize, not only the importance of seeking prenatal care early, but also the vital need of complete cooperation with their physicians.

This latter factor — cooperation — is often too little appreciated by laywomen who, through various channels, have become aware of such diseases as poliomyelitis, multiple sclerosis, and even muscular dystrophy, but yet are completely ignorant of the existence of the potentially lethal toxemia of pregnancy. Clearly, somehow, community education should be designed to include pertinent knowledge regarding the toxemia of pregnancy and the importance of adequate prenatal care in its prevention. Perhaps a National Foundation for Preeclampsia is the answer. *Editorial. A Preeclampsia Society? Internat. Med. Dig. July 1959.*

Now Disclosures Made to the Physician Are Privileged

Walter L. Oblinger, Associate Counsel

The 71st General Assembly, at the suggestion of the Illinois State Medical Society, enacted legislation designed to afford a measure of protection to disclosures made to physicians by their patients. The Act (HB 1280, Chap. 51, Ill. Rev. Stats, 1959, sec. 5.1) is as follows:

> "Sec. 5.1. No physician or surgeon shall be permited to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient, except only (1) in trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide, (2) in all mental illness inquiries, (3) in actions, civil or criminal against the physician for malpractice, (4) with the expressed consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health or physical condition, (5) in all civil suits brought by or against the patient, his personal representative, a beneficiary under a policy of insurance, or the executor or administrator of his estate wherein the patient's physical or mental condition is an issue, (6) upon an issue as to the validity of a document as a will of the patient, or (7) in any criminal action where the charge is either murder by abortion, attempted abortion or abortion."

The first thing to bear in mind is that the privilege belongs exclusively to the patient and may not be waived by the physician. As written, the prohibition against disclosure by the physician may be waived under only one of the seven exceptions enumerated in the statute.

A review of existing statutes in other states discloses that the privilege as it exists elsewhere contains one or more of the exceptions enumerated in the Illinois statute. Of course, the privilege did not exist at common law. The only privilege that did exist at common law was that between attorney and client, the purpose being to encourage the employment of professional advisers by persons in need of legal services and to promote absolute freedom of consultation by removing all fear on the part of the client that his attorney might be compelled to disclose in court the communications of the client or other information developed by the attorney during the course of his representation. Practically all of the states have statutes embodying this common law rule.

FIRST STATUTE

The first state to enact a statute protecting disclosures made to a physician appears to be New York, which in 1828[1] adopted language that served as a model for many other states. It provided:

> "No person duly authorized to practice physic or surgery shall be allowed to disclose any information which he may have acquired in attending any patient, in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him, as a surgeon."

Of course, the purpose of the statute was to encourage the patient, as a matter of public policy, to make full disclosures to his physician so that he could be properly and fully treated. Thus, it would appear, that the legislature decided that public policy required that its citizens be free to seek treatment for their injuries and ailments and that this consideration was more important than the need to get at the truth in a lawsuit.

With the passage of this type of legislation many unconsidered problems arose which worked

to the disadvantage of the patient. Other problems arose wherein the needs of justice outweighed the need for absolute privacy of communication between physician and patient. Hence, the legislatures began to enact exceptions to the absolute privilege.

PATIENT, PHYSICIAN, PUBLIC SERVED

As summarized in the Illinois statute, the patient's best interests are served under exception #2, where the patient is in need of mental treatment and his physician is the best person available to inform the court. Again under exception #4, it seemed wise to permit the patient to expressly waive his privilege or his executor or personal representative to sue upon a policy of insurance or on a personal injury claim where he was either dead or under some form of legal disability. Exception #5, as originally drawn and submitted to the legislature, stipulated that the privilege was impliedly waived when the patient brought a civil suit wherein his physical or mental condition was an issue and the physician's testimony was relevant to that issue. The legislature, in its wisdom, however, insisted that the ends of justice required that the physician testify also in those cases where suit was b r o u g h t against the patient and his physical or mental condition was in issue and struck the relevancy test, thereby leaving it exclusively to the courts to decide on which matters the physician should testify.

One of the problems sought to be overcome, *i.e.*, one which caused trouble to courts in other states where the privilege existed, was the lack of expert medical testimony in will contests. It would appear to be in the best interests of the patient that his physician be permitted to testify as to his mental condition at the time he executed the document sought to be admitted in probate as his will. This, then, was made an exception to the privilege under exception #6. Exceptions #1 and #7 were enacted as a matter of public policy so that in cases of murder, murder by abortion, or abortion, the courts could have the benefit of medical testimony. The purpose of exception #3 is to permit the physician to protect himself in cases of malpractice by permitting him to testify, produce medical records, or use other medical evidence in his defense. One authority[2] flatly states that if this exception did not exist, a physician would absolutely be at the mercy of an unscrupulous patient. Thus exception #3 attempts to prevent the use of the courts to reach an unjust result and may be justified on the basis of public policy.

That a need existed for this type of legislation has been well known to the medical profession for many years. Two of the principal problems have been, (1) the disclosure of admissions made by patients to physicians in lawsuits, for example, in divorce and separate maintenance, and (2) disclosures of admissions made by patients to physicians involving ailments not directly related to the lawsuit at hand.

APPLICATION OF THE LAW

In the first instance, several cases have arisen in Illinois, as illustrated by one case in the Circuit Court of Cook County,[3] wherein the plaintiff sought to question his wife's psychiatrist in a suit brought for alienation of affection. The physician claimed that any disclosures made were privileged. The court, without benefit of enabling legislation, sought to give the privilege status and upheld the physician and refused to permit him to answer. The case was not appealed, however, and the Supreme Court of Illinois has never had an opportunity to pass upon the question. If the problem had been presented to the Supreme Court, there is no question that it would have overruled the lower court and followed the common law rule.

It might be observed that the psychiatrist occupies a position quite similar to that of the attorney in consultations involving problems that evidence themselves in the form of neuroses and psychoses. Both the lawyer and the psychiatrist must receive from the patient information which may involve him in illegal, immoral, or other activity that may be detrimental to the patient if the information is made public or is disclosed to unauthorized persons. That the psychiatrist should be free to delve into all facets of the patient's life in an effort to solve his medical problems would appear to be self-evident. All too frequently, the problems confronting the patient, however, have legal ramifications, as in the case of extra-marital relationships. It was intended and it is hoped that the statute will serve to protect the psychiatrist-patient relationship and render the psychiatrist immune from court inquiry saving exceptions 1, 2, 3, 4, 6 and 7 above.

Inasmuch as exception #5 provides that the

issue before the court in the civil action must be one "wherein the patient's physical or mental condition is an issue," it would appear that the psychiatrist would not be permitted to testify in the divorce or separate maintenance situation or in other actions where the admission or disclosure is not directly related to the cause of action. However, it would appear that the psychiatrist would be subject to testimony in causes of action wherein the cause of action is on an issue directly affecting the patient's mental or physical condition, for example, cases involving traumatic neurosis, or other neuroses growing out of injury or wrongs committed against the patient.

INCOMPLETE SOLUTION

Insofar as disclosures made to physicians involving ailments not directly related to the lawsuit is concerned, it would appear that this statute falls short of complete solution. The classic case in point is the case involving a lawsuit brought by the patient for damages for injuries suffered through negligence of the defendant. The plaintiff claims that his back ailment or his broken leg was directly caused by the negligence of the defendant. The defendant, during the course of pre-trial discovery, seeks to obtain the complete medical history of the patient, which includes complete recovery from venereal disease, no ill effects being observable or demonstrable.

If the defendant is permitted to bring out this history, the lawsuit may have to be abandoned since the disclosure may result in unfavorable personal publicity, marital difficulties, etc. To permit the doctor to testify under these circumstances would certainly prejudice the plaintiff and might prevent recovery on a meritorious claim. However, not to permit him to testify might prevent the defendant from obtaining a medical history related to the injury thereby resulting in a miscarriage of justice. It would appear further that the problem, whether a particular medical history might have a bearing on the injury, is primarily a medical one.

Just how far the courts will go in the search for the truth in this situation is speculative. Regardless of the form of the statute, it is probably safe to say that the courts will jealously guard their right to determine what is relevant and material, and that they probably would have permitted testimony on both sides before ruling on the question of submitting the matter to the jury.

That the statute has created some problems is not unexpected. The first problem is whether or not the physician is precluded from asserting his lien for medical services under a new statute[4] also passed by the 71st General Assembly. For the reasons we outlined in a previous article[5], it would appear that the physician may comply with the Physician's Lien Act and furnish information concerning the injury, treatment, and medical history as related to him by the patient, *provided* the same appears on the doctor's medical records.

Another problem is whether the notations made on the medical records of the patient in a hospital fall within the purview of the privilege. Attention is called to the case of *Newman* v. *Blom*,[6] wherein the court in upholding the privilege, said:

> "The policy of the statute is to provide for great freedom of disclosure by a patient to his physician, for the patient is often in no position to know what disclosures may or may not be necessary for his proper treatment. We have also held that the statute should receive a liberal construction designed to carry out its manifest purpose to make consultation by a patient with his physician entirely confidential and free from anticipation or fear that this confidence will be broken by the examination of the physician, directly or indirectly, as a witness in some legal proceeding. Clearly, then, such a statute is intended to cover any information gathered from the patient and placed in a record by an attending, consulting, or treating physician, whether done intentionally, willfully, or under a law requiring its preservation. It is our conclusion that any such information placed upon such hospital records would be, and is, covered under the statute as privileged to the same extent that the knowledge and information of the examining or treating physician is privileged."

Whether Illinois will follow the law as enunciated by the Iowa court remains to be seen.

TESTIMONY FOR HOMICIDE VICTIMS

Another problem with interesting legal sidelights involves the construction of the language in exception #1. Note that the physician is free to testify in homicide cases but that his testi-

mony is limited to disclosures relating "directly to the fact or immediate circumstances of the homicide." It would appear that this poses no problem for the physician conducting an autopsy on the deceased; a private relationship between physician and client never existed and, of course, the privilege never arises. Furthermore, autopsies done under these circumstances would undoubtedly be ordered by the coroner and are provided for by statute[7]. Insofar as the physician treating the deceased prior to death is concerned, it would appear that he could testify objectively on the cause of death.

Would he be permitted to testify as to a dying declaration wherein the victim names the defendant as his assailant? It is generally held by the courts that the defendant in a criminal prosecution may not invoke the privilege of the victim and thus exclude relevant evidence which the victim's physician is in a position to give. No confidential relationship existed between the physician and the defendant; hence, no privilege exists[8].

In the case of *Davenport* v. *State*[9], the defendant was convicted of manslaughter. Physicians who had attended the victim testified for the state, over objection by the defendant, on the nature of his wound, treatment given, and the cause of death. There was no evidence showing consent or waiver of the privilege by the victim. A majority of the court, in a split decision, held that the defendant could not claim the privilege of the victim; therefore, testimony of the physicians was admissible.

The court, in the hypothetical situation above, might hold that the presence of the physician at the deathbed was incidental and that the victim's purpose and intention in making the statement was not for the purpose of being treated but to see justice done.

TESTIMONY FOR DEFENDANTS

A greater problem is posed for the physician who treats the defendant. Could a psychiatrist, for example, be compelled to testify on the homicidal tendencies of his patient when his opinion is based on observations and conferences extending over a considerable period of time prior to the act? What about admissions in the nature of a confession occurring after the fact? Likewise, there would seem to be a problem in the factual situation where the defendant expresses hostility to the victim and makes statements indicating that he intended to do him bodily harm. This might be construed to be a disclosure directly relating to the fact of homicide. What about observations as to the defendant's state of mind or physicial characteristics upon which the physician might reasonably conclude that this was a dangerous man but without any indication that he intended to do harm to any particular person, especially the victim? These are questions the courts must pass upon. The courts might very well exclude any testimony not directly related to the fact or to the immediate circumstances of the homicide disclosed to the physician in his capacity as a physician for the purpose of treatment.

Exception #7 does not appear to be limited in any way. It simply provides that in criminal cases where the charge is either murder by abortion, or abortion, that the privilege does not exist. In these cases, then, it would appear that the physician must testify as to any facts he may have competent to prove the charge.

CONCLUSION

Aside from the protection to the psychiatrist-patient relationship just what has the statute accomplished? First of all, the principle of privileged communication for the physician-patient relationship has been established. Secondly, the law has recognized the principle of medical ethics against the disclosure of matters received by the physician in the very private relationship between him and his patient. Thirdly, the physician is prohibited from making any disclosure in most legal situations including all criminal matters except murder or abortion, unless the privilege is waived through some conduct of the patient as enumerated in the statute.

REFERENCES

1. N.Y. Rev. Stat. 1828 II, 406, Part III, c. VII, art 8 s. 73.
2. Privileged Communications Between Physician and Patient by Clinton De Witt; Charles C. Thomas Publisher, Springfield, Illinois (1958), p. 251.
3. Binder v. Ruvell, Civil Docket 52c 3525 (Circuit Court of Cook County, June 24, 1952.
4. S.B. 1001, 71st General Assembly. Chap. 82 Ill. Rev. Stats. 1959, sec. 101.1 et seq.
5. Oblinger, Walter L.: The Physician's Lien. SB 1001, Illinois M. J. 117:81-82 (Feb). 1960.
6. 89 N.W. (2d) 349 (Iowa), 1958.
7. Chap. 31 Ill. Rev. Stats. 1959, sec. 10.2.
8. See Privileged Communications Between Physician and Patient, ibid, page 50 for discussion and cases cited in footnote.
9. 143 Miss. 121, 108 So. 433, 45 A.L.R. 1348 (1926).

Clinical-Surgical Conferences



Giant Hernia

Department of Surgery, Cook County Hospital

Moderator:
Robert J. Baker, M.D.
Associate Director of Surgical Education
Cook County Hospital

Discussants:
Arkell M. Vaughn, M.D.
Clinical Professor of Surgery, Stritch School of Medicine of Loyola University; Attending Surgeon, Mercy and Cook County Hospitals

Leo M. Zimmerman, M.D.
Professor of Surgery and Chairman of the Department of Surgery, Chicago Medical School; Attending Surgeon, Michael Reese and Cook County Hospitals

Dr. Robert Baker: We are delighted to have two eminently qualified speakers this morning, both of whom have been keenly interested in the surgery of hernia for many years. Dr. Vaughn has been a loyal attending surgeon at this hospital, and his service has written extensively on several aspects of hernia surgery. Dr. Zimmerman is world-renowned for his fine textbook dealing with every aspect of hernia, and we regard him as the "last word" on hernia in this hospital.

The correction of giant hernias has always posed a distinct challenge to the surgeon's resourcefulness and dexterity, the difficulties frequently being compounded by obesity and/or intercurrent cardiopulmonary disease. Incarceration is almost universally present, and the ubiquitous threat of obstruction to the intestinal flow militates for repair, after judicious preparation of the patient for this undertaking.

The peritoneal cavity actually becomes smaller after a large mass of viscera has escaped and resided outside it for a long period of time. The loss of this "right of domicile" of the herniated viscera has stimulated the search for adjunctive measures to increase the capacity of the peritoneal cavity, and we shall elaborate on this in the course of presentations.

The cases to be presented point up the trying physiological and technical problems inherent in patients who have allowed themselves to achieve the far-advanced defects we shall see.

Case 1.

Dr. Andrew Carney (Surgical Resident): This 64 year old white male was transferred to the surgical service for treatment of a giant left inguinal hernia of 20 years' duration. Hospital admission was necessitated by symptoms of diabetes mellitus which had been well controlled on the medical service with 30 units of PZI.

The patient stated that the hernia had been irreducible for the last 10 years, but he had not been aware of any gastrointestinal or genitourinary symptoms. He had, however, encountered increasing difficulty in walking because of the size of the hernia. Previous requests for therapy had been refused.

On physical examination the patient was well nourished but not obese. His blood pressure was 170/100 mm. Hg and pulse rate, 80 per minute; he was ambulatory, comfortable and cooperative. His heart, lungs and general condition had been



Fig. 1. Anterior view of the giant left inguinal hernia. The tape marks on the scrotum indicate the adhesive strapping necessary to prevent intraperitoneal air from penetrating into the hernia sac.

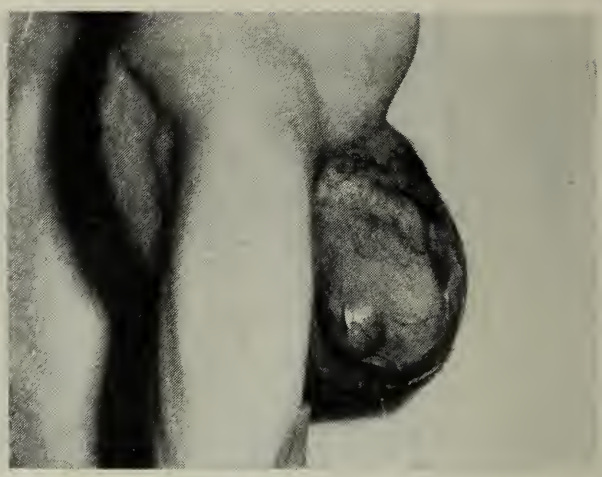


Fig. 2. Lateral view of the hernia from right side.

considered suitable for major surgery by the referring medical service. The abdomen was flat and free of scars or weaknesses with the exception of the left inguinal area which was the site of an irreducible, indirect inguinal hernia which extended into a huge scrotal sac with resultant obliteration of the normal male genitalia.

Routine roentgenograms and barium enema confirmed presence of the small bowel and major portion of the left colon within the hernial sac.

Dr. Baker: Before discussing this case, we will show some photographs of the patient (Figs. 1 and 2). Actually the hernia needs little description once you have seen these pictures. The patient came to the hospital because the mass was getting so large he could not put on his trousers. You will notice that the shaft of the penis is embedded in the hernia and the testicle is over on the right side. The flat x-ray projection of the abdomen shows the huge sac containing gas and fluid. The barium enema (Fig. 3) illustrates that this entire mass is large bowel, transverse colon, and sigmoid which have herniated into the sac. Adjacent to that are several loops of small bowel. The chest film (Fig. 4), taken during therapy the day before surgery, indicates the amount of pneumoperitoneum this patient achieved;

The patient was prepared for surgery by pneumoperitoneum, primarily. A total of 8,500 cc. of air was injected into the peritoneal cavity in divided doses, the first being 800 cc. and the last, 1,500 cc. He was also given castor oil and milk of magnesia just prior to surgery.

Dr. Leo M. Zimmerman: The most important lesson to be learned from a case like this is not to let it happen. In this day and age, with all the means of communication and education and with the training of physicians, there is no earthly excuse for a hernia ever reaching this



Fig. 3. Barium enema showing air-filled small bowel loop and barium-containing transverse colon in hernia sac (arrow). Arrow is at level of the pubis.

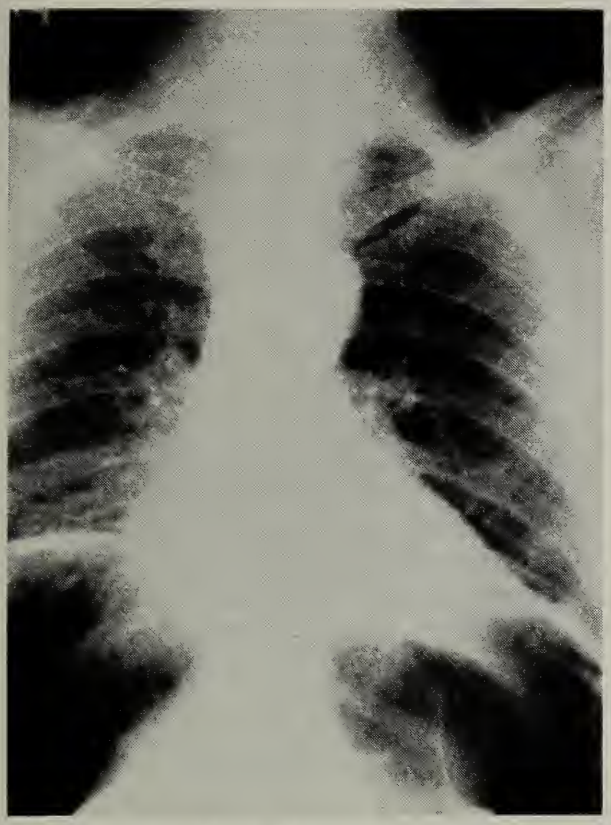


Fig. 4. Upright PA chest film, showing amount of pneumoperitoneum achieved over a month's time.

size. We are told that the patient is 64 years old, that he had had the hernia for 20 years; perhaps he had had it nearer 30 or 40 years. Suppose he had been operated upon 20 years ago at the age of 44 before he developed diabetes and his other problems. Would there not have been a great deal less general hazard as well as less local difficulty in repairing the hernia? What has he accomplished by carrying it around for 20 years? It has impaired his earning ability, his comfort, his normal way of life. He has now arrived at the point where he must have a more serious operation at a worse time of his life.

There is only one treatment for inguinal hernia, and that is operative repair when it is first recognized. Any physician who advises waiting —unless there is some excellent medical reason why the patient should not be operated upon as soon as the hernia is discovered—is doing the patient a disservice. The more emphatically we teach that and advocate it, the fewer of these problems we shall have to contend with, and there will be fewer deaths from intestinal obstruction and fewer recurrences from routine repair of inguinal hernia. Patients who are reluctant to have herniorrhaphy performed should have a case such as this cited as a possible result of their diffidence.

Actually there are two medical worlds: One is the world of a county hospital, and the other is the world outside. In the outside hospitals we do not see this type of hernia very often, whereas it is fairly common in a county hospital. I had a postoperative death from a hernia like this years ago, but I don't think I would have that death now; it was from the respiratory embarrassment caused by the reduction of the large percentage of abdominal content which had been out of the abdomen for so many years. I think there was something else in that particular case, too; I fought the bowel to get it back in, and I am sure, as the result of trauma, there must have been dilatation and distention of the loops of bowel in addition to the solid mass of bowel and omentum that had to be reduced. The patient was an obese, short-necked, thick-chested man with a limited respiratory reserve. This happened many years ago but I don't think it would happen now.

The problem, of course, is how to get the bowel or whatever viscera are in the sac, back into the abdomen without overcrowding. But there are other problems too. Here the barium enema showed a large portion of the colon in the sac; part of this was transverse colon—and that is not likely to be a sliding hernia—but is colon with a long enough mesentery so that it enters the sac in the same way as the small bowel and will be reducible in the same way that the small bowel is. However, in massive hernias of this type it is more often the rule that one is dealing with a sliding hernia, that that part of the colon in the sac actually lies within its wall and cannot be reduced in the ordinary fashion. There are also problems associated with extensive adhesions of the bowel loops to the wall of the sac which may make for difficulty in reduction and in eventual repair of the hernia.

I don't know whether this patient could have tolerated this amount of intestine being restored to the abdomen. There were two things in his favor: (1) he was not too obese, and it is the obese abdomen that has no room for any additional structures, and (2) he was in good general condition without evidence of respiratory or cardiac impairment.

I believe the treatment used here was excellent. Of all the measures that are available for increasing the capacity of the abdominal cavity, I think pneumoperitoneum is probably the most effective and least damaging. If you produce a very large ventral hernia by cutting across the muscles of the abdominal wall, as advocated by Womack,[4] you have facilitated the repair of one problem but have created another, and the same holds true for phrenicectomy.[3]

I would like to say one more word about the respiratory and circulatory embarrassment which might be associated with such a hernia. In addition to the actual volume of intestinal content and of omentum, I think there is also a component of intestinal distention from the mechanical handling of the bowel in getting it back. I think that not only should this handling be reduced to a minimum but also that an indwelling tube should be started immediately at the time of operation to minimize the amount of additional space occupied by distant small bowel.

Dr. Baker: By the term "indwelling tube" do you mean a Levine tube in the stomach or a long intestinal tube, such as a Harris or Miller-Abbott?

Dr. Zimmerman: I would use an ordinary gastric tube.

Dr. Baker: Dr. Vaughn, what would be your management in this case?

Dr. Arkell M. Vaughn: I want to emphasize the point Dr. Zimmerman made about operations in the aged. These hernias should be operated upon when they are first seen. A few years ago we reviewed 300 cases of hernia by age groups. This was a study on patients at Mercy and Cook County Hospitals, and we learned the following facts: We had 82 patients in the 60 to 70 age group at Mercy, and there were 103 in the same age group at the Cook County Hospital. Elective surgery was done on 80 patients at Mercy and 97 at County; at Mercy 2 operations were emergency procedures, and at County there were 6. Those were all in the 60 to 70 year age group. In the group between 70 and 80 years of age, there were 32 seen at Mercy and 69 at Cook County; in this group elective surgery was done in 28 at Mercy and 64 at County. Emergency procedures were carried out in 4 patients at Mercy and 5 at County. In the next group, 80 to 95 years, there were 4 patients operated upon at Mercy and 10 at County; elective surgery was performed on 3 at Mercy and 7 at County, and emergency surgery in 1 at Mercy and 3 at County. The total series comprised 300 cases, of which 279 were elective and 21 emergency.

Some complications developed such as pulmonary embolism, penumonia, atelectasis, and others. In the 80 to 95 year group, we had no deaths —a mortality rate of 0%. The mortality rate in the 60 to 70 year group was 4.9 per cent at Mercy and 2.0 per cent at the County Hospital; this makes us firmer in our belief that any patient who has a hernia should be operated upon early. Certainly, if the patient here were only a few years older, this operation would have been a very great risk.

As to preoperative care, especially in the male, we do a proctoscopic examination, barium enema, and urologic examination—specifically, residual urine determination — routinely before herniorrhaphy. Many of these patients have a prostatic obstruction and will have to strain to urinate; they should have a transurethral procedure done first. I have seen cases where transurethral resection was done and the hernia was much improved afterwards. If urinary obstruction is not relieved, these cases are apt to break down from the intra-abdominal pressure of straining. Barium enema will rule out a lesion of the bowel. Pneumoperitoneum is very useful in preparation of these cases for surgery.

As for repair of the hernia, some men use various materials in the repair. In an inguinal hernia we usually have enough material without using any foreign substance. In ventral hernia sometimes we have to use a material such as stainless steel mesh, which I do not like, or tantalum mesh, which in our experience has been better. I attended the interim session of the American Medical Association in Dallas in December, and saw two motion pictures on this subject, one by Dr. Usher of Houston, who had a picture on intraperitoneal repair of an incisional hernia with Marlex mesh, and the second by Payne. Dr. Usher's repair involved removal of the peritoneum entirely and then placing the mesh directly in the abdominal wall next to the bowel. His theory was that omentum would implant and cover over the mesh to form a new layer, so he sutured the wound without imbrication. Dr. Payne used nylon or dacron mesh; he closed the peritoneum, put the mesh outside the peritoneal closure, and imbricated the muscles

over it. Some men report good results with these meshes, but not all surgeons find them satisfactory.

Dr. Baker: Dr. Freeark was the operating surgeon and will discuss the management of this case.

MANAGEMENT OF CASE 1

Dr. Robert J. Freeark (director of surgical education): We decided to prepare this patient with pneumoperitoneum, and as we filled the abdominal cavity with air, there was the natural tendency for the hernia to enlarge too. We took measurements with a tape from the pubis to the ischium, and there was a moderate increase in size of the hernia as the abdominal girth increased. His initial waist measurement of 34 inches increased to 37 inches over the course of the month of pneumoperitoneum. Room air was introduced with a 50 cc. syringe and a 3-way stopcock. Procaine was injected in the left upper quadrant of the abdomen, and an 18 gauge needle was inserted through the peritoneum. The first dose of air was about 800 cc. That was rather rapidly absorbed by the peritoneal surfaces, but after a week we gave about 1000 cc., and it was less rapidly absorbed; the first instillation gave some discomfort with shoulder tip pain. The total air injected was about 8,500 cc.

The value of pneumoperitoneum in the diagnosis of lesions of the liver, spleen, and diaphragm was emphasized to me in the course of this study. We could outline the entire spleen, and any gross irregularity of the liver would have been apparent.

As for the operative procedure, the standard left inguinal hernia incision was made, much as one would use for any hernia. In this case we used a Laroque approach, making a counter incision in the abdomen in the region of McBurney's point. The muscles were split; the free peritoneal cavity entered. A large gush of air came out, collapsing the abdominal wall. Twelve feet of intestine and the entire colon were involved. We had prepared the colon previously, in the event we injured it or felt it was necessary to resect part of it. The sigmoid was a slider, was reduced, and brought out through the McBurney incision. The hernia was repaired without inserting any prosthetic appliance. The McBurney incision was closed after reducing the hernia completely. Repair has remained intact for about 2½ years. We did the pneumoperitoneum over a period of a month and did not feel rushed.

Dr. Zimmerman: I want to say one thing and that has to do with the method of reducing a sliding hernia, which is a controversial subject. The methods for reducing the content of a sliding hernia are described in the literature; both are difficult and both are complex. Then there is a very simple method which I have described and have found effective in every sliding hernia I have had for years. Many years ago Dr. Arthur Bevan called attention to a sliding hernia and made it sound very complex and very serious, and his method of repair was so complicated that I could not attempt to draw it for you on the blackboard. But, visualize if you can, an open sac with a loop of colon forming part of the posterior wall of the sac; he made parallel incisions through the peritoneum of the sac and turned over flaps under the bowel to create a mesentery; then he put in a series of concentric purse-string sutures so that stepwise this colon, with its newly created mesentery, was reduced into the peritoneal cavity.

The most popular way of dealing with sliding hernia has been to make a separate incision in the abdomen and pull the bowel up from above. Originally, a free incision was made, the bowel was pulled up and perhaps anchored in the peritoneal cavity, and repair was effected from below. Then there is an in-between method in which a short incision is made through the internal oblique and transverse muscles and the bowel reduced from above with repair through the initial inguinal incision, as was used in this case.

I think the tendency to make this a difficult problem stems from a misconception in the minds of those who do the operation as to the position of the colon in sliding hernia. The surgeon visualizes the colon as lying on an immovable structure like the iliopsoas muscle, and he sees no way of getting it back up. But this is not true. If a portion of the bowel has entered the sac of a hernia, it has left the peritoneal cavity, passed through the abdominal ring, and lies within the spermatic cord. If it will slide in there, it will also slide out. If it will come up out of the sac as you pull it from above, why will it not come up more easily if you push from below with a minimum of dissection of the sac from the other structures?

I treated a sliding hernia two days ago, and I

treated it as I have all of them for years. When I suspect the presence of a sliding hernia, I make the incision high at the neck of the sac and on the anterior side. If it is made lower, there is danger of opening the bowel. In this particular hernia there was no free peritoneum. The entire mass was made up of bowel, and it would have been easy to have damaged that colon. Because I had reduced the reducible portion of the bowel, I closed that sac with purse string sutures; and with a little dissection and a little push from below, that mass returned into the properitoneal space, and there was no need for making a difficult operation out of it.

Once you have reduced it above the abdominal inguinal ring, then close the ring below that mass, and you have done everything you need to.

Dr. Baker: Dr. Vaughn has mentioned that he occasionally has need to use foreign materials of some type in a difficult large hernia in which the tissues are not of good quality. What are your feelings about this?

Dr. Zimmerman: In inguinal hernias, I find good local tissues for repair, and it is only in ventral hernias that I use a prosthesis. Dr. Vaughn, I believe, was referring to ventral hernias. I never use any prosthesis in primary inguinal hernia. In a recurrent inguinal hernia, if I feel something additional is needed, my first choice is fascia lata. I have not yet used any foreign substance in the inguinal region except in one instance. In a large ventral hernia where no tissues are available for repair, one must have recourse to some foreign substance, whether it is tantalum or stainless steel or what not.

Dr. Baker: I might mention that I was a witness to this surgical procedure, which was an exceedingly difficult one and was accomplished in a minimum of time, as shown by the fact that spinal anesthesia was quite sufficient. It was everyone's feeling that Dr. Freeark had done the impossible by reducing it at all, though the value of pneumoperitoneum was apparent when the abdominal wall collapsed as the McBurney incision was opened. Koontz[1] and Moreno[2] have reported such good results with this technique that we felt it was worth trying, and that was well borne out.

The other devices available, catharsis for the two to three days preceding surgery and use of the Miller-Abbott tube, were also employed.

Case 2.

PRESENTATION

Dr. William Norcross (surgical resident): This 37 year old white female was admitted to Cook County Hospital on November 12, 1959, with chief complaints relating to the presence of a large umbilical hernia. She was the mother of four children and had noticed this mass first 10 years earlier, during her second pregnancy. Progressive increase in size had occurred so that it was melon-sized with the third pregnancy, and the size of a volley ball with the fourth pregnancy 6 years previously. Both of these confinements had proceeded uneventfully. The patient had never tried to reduce the hernial contents but had worn a special corset for several years. She admitted that she had been troubled by periodic excoriations of the skin at the apex of the hernial mass, but had had no gastrointestinal or systemic complaints.

Physical examination revealed a well developed, obese, white female with an umbilical hernia the size of a basket ball. The overlying skin was excoriated with crusts and raw weeping areas. The patient was 5 feet 2 inches tall and weighed 216 pounds. Vital signs, routine laboratory tests, and general physical examination showed nothing remarkable. The hernia was irreducible but appeared to have a neck approximately 12 cm. in its greatest diameter.

Pelvic examination and the menstrual history suggested a normal pregnancy in the fourth month of gestation.

DISCUSSION

Dr. Baker: This 37 year old woman was admitted with pregnancy and this long history of a large umbilical hernia. Six years prior to her pregnancy had been uneventful, but she came to the hospital on this admission because she was afraid of the consequences of the hernia in this, the fifth pregnancy.

Again, before we discuss the case, I would like to show you some pictures. These pictures were taken on operating table (Figs. 5, 6). The ulcerated area was due to her girdle or corset and was a simple pressure phenomenon that cleared up promptly with proper treatment. The mass was lobulated and we felt that the defect was much smaller than the mass. Before we talk about what was done in this case, I would ask Dr. Vaughn to discuss the problem of what the management should be, especially in the face of the pregnancy.



Fig. 5. Lateral view of basket-ball size umbilical hernia in 37 year old pregnant woman.

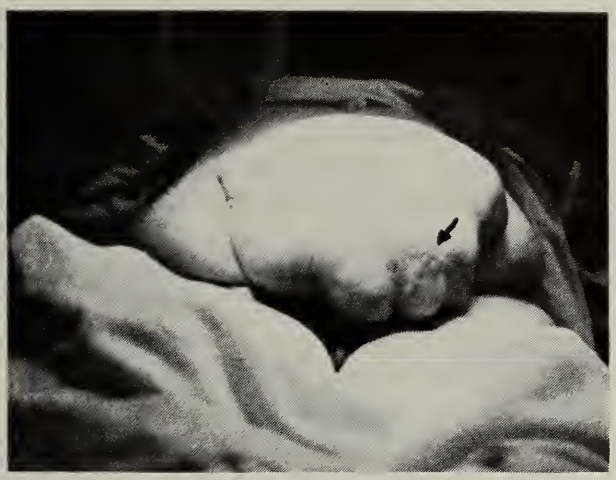


Fig. 6. Ventral view of umbilical hernia, showing healed ulcerated area (arrow).

Dr. Vaughn: This kind of patient comes to the doctor in private practice too, and you just tell her to go home and reduce about 50 pounds, and you hope in the meantime she will go to one of your competitors rather than come back to you for surgery. This was a pregnant woman, and as a County case is different from a private patient. Ordinarily in a woman four months pregnant who has gone through pregnancy before without trouble, the plan might be to carry her along with a belt and let her have her pregnancy and then repair the hernia. Ordinarily I would be inclined to do that in private practice. If she was a good private patient, I would content myself with conservative treatment and operation after the pregnancy was finished. Also, you have to consider what will happen to your sutures if you operate and the pregnancy continues and the abdomen expands with the pregnancy. There is the real possibility the hernia will recur.

Dr. Freeark: We debated this quite a bit at the bedside, the attending surgeon concurring in our approach. One of the strongest advocates of surgery was the patient's husband; he had urged her to have the hernia repaired from the time it first appeared, and the presence of pregnancy was not known to her when she was admitted. We thought it could be repaired without a great deal of stress on the intra-abdominal contents. The neck of the hernia was quite tight. She was not symptomatic, but the hernia was irreducible and quite tender, and excoriations were present. Most obstetricians recommend repair of umbilical hernia during pregnancy, preferably in the middle trimester.

Dr. Baker: At surgery a 10 cm. transverse defect was found, and the small bowel and right colon were adherent to the under side of the sac throughout. This case demonstrated the axiom that although the hernia itself may be very large, the gap in the abdominal wall is usually of moderate size, and the repair of the hernia proper is not too difficult. The main difficulty here, technically, lay in the very extensive adhesions between the sac and the adjacent loops of bowel.

In freeing the bowel, the mesoappendix was traumatized, and a hematoma developed. Subsequently, when the bowel was entirely freed, it was felt that the appendiceal circulation might have been compromised, and an appendectomy was performed. The defect was closed in the Mayo fashion and the patient has done well.

Is appendectomy indicated when the appendix is encountered in the course of such herniorrhaphy, or is it ever indicated in any hernia repair? Would you be prone to think differently in light of the hematoma of the mesoappendix?

Dr. Zimmerman: A lot has appeared in the literature on this subject dealing with appendectomy during a herniorrhaphy, and a paper was read before the Surgical Society here in Chicago recently. My feeling is that we must keep our eyes on the ball. We are there to repair the hernia, and we must do that with a minimum of hazard. Herniorrhaphy is a perfectly clean operation; if there is contamination, it comes from outside. To cut across the appendix introduces an element of contamination that is not justified. You have introduced the hazard of infection.

If you do much manipulation, you will dilate the ring and increase the size of the hernia. As

an elective thing, the appendix should not be removed during hernial repair. I have many times pushed it away and only once in a while have had to remove it. In this case, it had to be removed. Sometimes the mesoappendix is in the sliding hernia, and there is no way that you can really adequately take care of that except by removing the appendix. Of course, if you find concomitant acute appendicitis, you have to remove it, but not otherwise in an elective hernia repair.

Dr. Vaughn: I feel the same way. I do not think a normal appendix should be taken out at the time of elective surgery for hernia because of the chance of infection, but there are conditions when the appendix lies in the hernial sac. If you run across such a case, take it out at that time, but ordinarily I would not recommend it. I do not think it is good surgical procedure.

Dr. Baker: No one knows as much about the confusing terminology of hernia as does Dr. Zimmerman. Is it true that Graham's approach to sliding hernia is through two different incisions and Laroque's is through one, or are they both the same?

Dr. Zimmerman: I think the Laroque term refers to intraperitoneal herniorrhaphy. Laroque was an excellent surgeon in St. Louis, and he devised a technic of operating from within the peritoneal cavity; when you pull the sac up into the peritoneal cavity, that is a Laroque maneuver and repair is from within. I do not think he ever wrote anything on sliding hernia specifically. The separate incision in the abdominal muscles above the inguinal area, I believe, Graham used first.

Littré was a French surgeon, who described cases in which there were diverticula of various types in the hernial sac. I do not think they were loops of bowel but were incarcerated or strangulated intestinal diverticula. The description of the condition is inadequate, so that you cannot be sure exactly what they were. The possibility is that they contained both preformed diverticula, like the appendix or a Meckel's diverticulum, and a partial enterocele. Richter 60 years later described this phenomenon of partial enterocele in which a portion of the circumference of bowel is drawn into a small hernial ring or sac and becomes strangulated. It occurs more commonly in femoral hernia than in any other type. The significance of this is that a person can have a strangulated hernia without intestinal obstruction because the lumen of the bowel is not compromised. Also, it is difficult to recognize because the amount of bowel in the sac is so small that it does not form a mass that can be felt. This partial enterocele is usually called the Richter hernia, and Littré's name refers to preformed diverticula whether they represent the appendix or Meckel's diverticulum, or other forms in a hernia.

Dr. Freeark: One of the most difficult problems in emergency surgery at this hospital is the giant ventral hernia associated with acute bowel obstruction. Patients often have this excoriated skin, and we usually advise putting a Miller-Abbott tube down, and temporize in that fashion. These cases have a tremendous mortality rate. It has been emphasized that all you need do is to cut the neck of the sac and relieve the obstruction and not try to cure the hernia, because reducing this distended intestine will never be tolerated by the respiratory system. However, in this case, the incarcerating mechanism was not at the neck but at the dome of the sac, and complete exposure of the entire hernia was required, leaving the difficulty of closing the entire hernia.

ULCERATION AND OBSTRUCTION

Dr. Zimmerman: One of the complications we have in large umbilical hernia generally is not only excoriation but actually decubitus ulceration of the skin so that some of these patients have had to be operated upon because their skin was so thin there was danger of rupture. There are cases reported of spontaneous rupture of the umbilical hernia with eventration through the orifice. Of course, again, these things should not happen; the patient should be operated upon eariler. It seems to me that obesity of the body is associated with a similar state of the mind, and you get resistance to logic. Dr. Vaughn suggested that you send these patients home to reduce, with the hope that they will go to somebody else. They may do that, but you may be sure they will not reduce.

If you have a patient with symptoms of obstruction, there is a great hazard in not recognizing that the obstruction may be a strangulation. In this particular type of hernia it may be almost impossible to say whether an obstruction is a simple, mechanical one due to a kink, or is frank strangulation; I do not believe we can temporize and go by the clinical signs. In these

large irreducible ventral hernias, I think it is impossible to make a differentiation between the conditions by clinical means; many a patient has been carried along with the idea that it was a simple obstruction which could be relieved by suction, but they developed bowel necrosis which required extensive resection. So you have no choice but to operate. It is true that one might find obstruction in the apex of the sac, but that is not apt to be strangulated. Therefore, I would be very much inclined to do a simple incision of the neck of the sac and try to carry the patient over the acute obstruction and then do a definitive operation when the excoriations are cleared and the patient is rehabilitated. There is not much chance that obstruction at the dome of the sac is strangulated.

Dr. Baker: When you talk about opening the neck of the sac, is that an extraperitoneal incision? Is it necessary to enter the free peritoneal space?

Dr. Zimmerman: No. I see nothing to be gained by opening the peritoneum. You open the ring in the vertical direction because there is enough aponeurosis, so you can enlarge the ring and you relieve the pressure. After the acute symptoms subside, you can deal with the hernia later.

REFERENCES

1. Koontz, A. R. et al.: Preoperative Pneumoperitoneum as an Aid in Handling Giant Hernias, Ann, Surg. 140:759-762, 1954.
2. Moreno, I. G.: Clinic Eventrations and Large Hernias: Preoperative Treatment by Progressive Pneumoperitoneum. Original Procedure, Surgery 22:945-953, 1947.
3. Touroff, A. S. W. Phrenicectomy as Aid to Repair of Large Abdominal Hernias, J.A.M.A. 154:330-332, 1954.
4. Ziffren, S. E., and Womack, N. A.: Operative Approach to Treatment of Gigantic Hernias, Surg. Gynec. Obstet. 91: 709, 1950.

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120th Annual Meeting

Illinois State Medical Society

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EDITORIALS



Changes in personnel

In the reorganization of the Journal staff we have selected Miss Martha E. Dana, as assistant editor, to serve on a full time basis in the headquarters office.

Miss Dana comes to us with a substantial background of training and experience in editorial work. Though she hails from New York, she was an industrial editor at Armour and Co. in Chicago, then news editor on JAMA for five years before going East. There she was liaison editor of Pfizer Spectrum for over six years. In addition, she has done free lance medical writing. Miss Dana has her M.A. degree from the Medill School of Journalism at Northwestern University. Her familiarity with state and national medical organizations and her experience in editing clinical articles, as well as knowledge of the techniques of magazine production should serve us well.

Leaving the Journal staff at this time, are Miss Marion Carey and Mrs. Caroline Boeckmann. The editor wishes to thank Miss Carey, his right hand bower at the Tribune, for her assistance on a part time basis over the past eight years in the editorial minutiae required to produce our IMJ. For some time she has wanted to devote her spare time to historical research, but stood loyally by until the new journal staff was completed.

To Mrs. Boeckmann, who entered the Chicago office November, 1957, on a part time basis, we give our deep appreciation for her untiring attention to the details of producing and assembling IMJ material and cheerfully assuming steadily increasing duties over the past two years. She leaves us with a plan to resume part time medical research.

Obesity-hypoventilation-syndrome

Many extremely obese individuals are dyspneic on exertion. Hackney et al.[1] conducted extensive pulmonary studies on 17 patients (mean weight, 317 pounds) and found the total lung capacity and the expiratory reserve volumes were less than predicted values. The residual volumes were essentially the same.

Most of the patients had an elevated diaphragm encroaching on the intrathoracic space. In addition, the intra-abdominal pressure of the obesity-hypoventilation-syndrome patients was elevated in the supine position and also when they sat up. There was definite alteration of pulmonary dynamics as demonstrated by many blood and air studies. All these patients experienced dyspnea on normal exertion but had no polycythemia, somnolence, nor right heart failure.

The authors found a definite abnormality of the pattern of intra-abdominal pressure during the respiratory cycle of the patients. They found that in normal individuals intra-abdominal pressure increased during inspiration and dropped a corresponding level during expiration. These

1. Hackney, J. D. et al.: Syndrome of Extreme Obesity and Hyperventilation, Ann. Int. Med. 51:541 (Sept.) 1959.

studies were done with the individual in a sitting position. In contrast, in patients with the obesity-hypoventilation-syndrome they noted during inspiration a sharper increase in abdominal pressure that did not change, or actually increased, during expiration. They found that the pattern was not due to lack of diaphragmatic excursion but to retention of carbon dioxide.

Improvement occurred, however, after diuretics and digitalis were given and a salt-free diet was instigated. Further improvement followed weight reduction and the elimination of other pulmonary factors that contributed to the difficulty in breathing. Appropriate antibiotic therapy was indicated in six patients with pneumonia.

Chicago transit authority accidents

It is the primary and constant objective of the Chicago Transit Authority management to provide efficient and safe transportation for the public. A very important part of this program or policy is having physically fit bus drivers and Rapid Transit motormen. A brief outline of how these employees are selected may be of interest.

The pre-employment examination of applicants for bus drivers is very carefully carried out. Before the individual is seen in the medical department, the employment department investigates the applicant regarding past experience, aptitude test, intelligence, social and court records, motivation, and personality traits.

The medical examination includes a complete medical history, a thorough physical examination with special emphasis on vision, hearing, blood pressure, heart, lungs, and kidneys. In addition, a urine examination, electrocardiogram, and chest x-rays are done. A further aid in the selection of medically sound employees who have had military service is the Military Service Medical Record. In several instances disqualifying factors have been revealed in these records which the applicant had failed to mention in his voluntary medical history.

An intensive training program follows the rigid examinations. The CTA program for drivers includes an initial period of formal training, demonstration, and practice driving; periodic refresher programs on current safety needs, and a comprehensive individual retraining clinic for the few operators who fall below the acceptable safety standards.

A careful medical record of all employees is kept after they are hired. As part of this program a physical examination is given all those who have been off duty seven days or more due to any illness.

Regular annual periodic physical examinations are required for all bus drivers, Rapid Transit motormen, towermen and other operating personnel who have reached the age of 45, whether or not they have been ill. A mobile medical bus sent to various CTA depot centers is especially designed and equipped for these complete physical examinations including electrocardiograms and is staffed by a well qualified examining physician and a registered nurse.

If the annual examination shows the employee is physically fit, he is approved to continue his work. On the other hand, if a defect affecting his ability to operate safely is found, he is immediatedly disqualified and referred to the CTA central medical department. Here the employee is rechecked and referred to his family doctor for treatment. Disposition of the case subsequently depends on the underlying medical problem. However, the majority of employees are handled in the following manner:

1. Approved for their regular work, provided treatment affects recovery.

2. Transferred to another job, if possible, where consideration of public safety is not the prime factor.

3. Disapproved permanently and placed on disability pension. In these instances the medical condition is not amenable to treatment. During treatment by the family doctor, the Medical Department maintains close contact and cooperates in any way possible.

The year 1959 marks the fifth consecutive year that the CTA public accident rate has fallen to an all-time low. This is in distinct contrast to the highway accident record of private auto drivers, which has increased each year.

In conclusion, the CTA management's strong conviction that careful selection of drivers, plus a well-planned training program and close medical supervision distinctly contribute to reduction of the accident rate is supported by the gratifying reductions in accident frequency rates it has achieved in the last five years.

George H. Irwin, M.D.
Medical Director
Chicago Transit Authority

Annual meeting program changed

At the organization meeting held last November, officers of the twelve scientific sections which compose the Committee on Scientific Work met with an Ad Hoc Committee of the Council and discussed how the scientific part of the annual meeting could be improved.

Physicians attending the 1960 meeting will find that the general sessions especially have been broadened. A number of outstanding speakers from all sections of the country will participate.

Ten per cent for sixty-five

And don't forget to mention cost when debating the Forand Bill introduced Feb. 18, 1959. It provides a scaled tax on employer and employee that totals 5 per cent to begin with but increases to 9½ per cent by December 31, 1968, when each will be required to pay at an equal rate amounting to 4¾ per cent. It is unlikely that the rate will remain at this figure since taxes usually go up and not down. For a young man with a family the Forand Bill dictates a steep price to pay for insurance against the cost of hospital, nursing home, and surgical service some 35 to 40 years hence when he becomes eligible for old age and survivors insurance benefits. This tax, of course, added to his other taxes leaves him with a decreasing take-home-pay check just at a time when his family expenses are mounting. While he is healthy and ready to enjoy a full life, he has little left to finance that life.

The fruits of years of weekly pay deductions will never materialize unless he lives to be 65, and after that only to provide the where-with-alls to cover that part of his old age he hates to think about.

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"If the shoe fits . . . "

Unfortunately, too few medical people are really interested in preventive medicine and health maintenance. I deplore the truth in the cynicism of a medical leader who remarked that any second year medical student gets easily interested in a case of pernicious anemia but it takes an excellent doctor to be interested in the normal person. Perhaps it is you, and your colleagues, interested in school and community health, who must help develop the interest and participation of physicians, individually and collectively. *Herbert T. Wagner, M.D. A Physician Looks at Education in Health and Fitness. J. Indiana Med. Ass. Dec. 1959.*

Program

One Hundred Twentieth

Annual Meeting

Illinois State Medical Society

Hotel Sherman **Chicago**

May 23, 24, 25, 26, 27, 1960

1960 Annual Meeting, Illinois State Medical Society

Program Summary

Monday, May 23

8:00 p.m. First meeting, House of Delegates
Louis XVI Room

Tuesday, May 24

9:00 a.m. Section on Obstetrics and Gynecology
Crystal Room

Section on Cardiovascular Disease
Old Chicago Room

Section on Eye, Ear, Nose and Throat
Gold Room 114

10:00 a.m. Reference Committees of the House
Jade Room
Polo Room
Holiday Room
Orchid Room
Life Room
Time Room
Gold Coast Room

12:00 noon Public Relations Luncheon
Louis XVI Room

Fifty Year Club Luncheon
Assembly Room

1:30 p.m. Section on Radiology
Crystal Room

Section on Surgery
Ballroom

Section on Eye, Ear, Nose and Throat
Gold Room

Reference Committees as needed:
Jade Room
Polo Room
Holiday Room
Orchid Room
Life Room
Time Room
Gold Coast Room

3:30 p.m. Section on Anesthesiology
Old Chicago Room

Wednesday, May 25

8:00 a.m. Women Physicians' Breakfast
Orchid Room

8:30 to
10:00 a.m. Second meeting, House of Delegates
Louis XVI Room

9:00 a.m. GENERAL ASSEMBLY
The Ballroom

Section on Pediatrics
Crystal Room

12:00 noon Section on Pediatrics Luncheon
Old Chicago Room

1:30 p.m. GENERAL ASSEMBLY
The Ballroom

7:00 p.m. Annual Dinner
The Ballroom

Thursday, May 26

9:00 a.m. Third Meeting, House of Delegates
Louis XVI Room

Section on Medicine
Crystal Room

Section on Dermatology
Old Chicago Room

Section on Allergy
Gold Room

Section on Preventive Medicine
Jade Room

Physicians' Association
Room 107

American College of Chest Physicians
The Ballroom

12:00 noon American College of Chest Physicians
Luncheon
The Bal Tabarin

Section of Medicine Luncheon
Crystal Room

Section on Dermatology Luncheon
Old Chicago Room

1:30 p.m. GENERAL ASSEMBLY
The Ballroom

Friday, May 27

9:00 a.m. Section on Pathology
Crystal Room

12:00 noon Section on Pathology Luncheon
Old Chicago Room

2:00 p.m. Illinois Association of Blood Banks
Crystal Room

Council and House of Delegates Meetings

Council meetings will be scheduled each day of the annual meeting as provided under the Constitution and By-laws:

Monday evening, May 23, 6:00 p.m.	Dinner Meeting Room 107
Tuesday morning, May 24, 8:00 a.m.	Breakfast Meeting Room 107
Wednesday morning, May 25, 7:30 a.m.	Breakfast Meeting Room 107
Thursday noon, May 26	Luncheon meeting following adjournment of the House Room 107

Meetings of the House of Delegates have been scheduled as follows:

Monday evening, May 23, 8:00 p.m.	Opening meeting Louis XVI Room
Wednesday morning, May 25, 8:30 a.m.	Second meeting Louis XVI Room
Thursday morning, May 26, 9:00 a.m.	Third meeting Louis XVI Room

Programs for Tuesday, May 24

Section on Eye, Ear, Nose and Throat

Wiley H. Harrison, Chairman ..... Chicago
Wilbur W. Baumgartner, Secretary .. Kewanee

TUESDAY MORNING, May 24
Gold Room 114

9:00 "Dynamics of the Development of the Chick Otocyst"
Tawfik Girgis, Chicago
Northwestern University Medical School

9:20 "Management of Facial Fractures by External Fixation"
W. A. McNichols, Dixon

10:00 Recess To View Exhibits

10:30 Business meeting and election of 1961 section officers

11:00 "Kodachrome Clinic of Ear Diseases"
Richard A. Buckingham, Chicago

11:30 "Lesions in the Mouth"
Marcus R. Caro, Chicago

Section on Obstetrics and Gynecology

Michael H. Boley, Chairman ..... Chicago
Robert R. Hartman, Secretary ..... Jacksonville

TUESDAY MORNING, May 24
Crystal Room

9:00 Panel: "Blood Dyscrasias in Pregnancy"
Moderator: Louis R. Limarzi, Chicago
Panelists: William R. Best
John Louis
Hematology Division of the Department of Medicine, University of Illinois College of Medicine

9:45 "The Successful Conquest of Chronic Vaginitis"
H. Close Hesseltine, Chicago
Mary Campeau Ryerson Professor of Obstetrics and Gynecology, University of Chicago

10:30 Recess to View Exhibits

11:00 "Amenorrhea — Its Diagnosis and Management"
William C. Keettel, Iowa City
Professor of Obstetrics and Gynecology, University of Iowa Medical School

Business meeting and election of 1961 section officers

Section on Cardiovascular Disease

Ernest G. McEwen, Chairman ..... Evanston
Theodore Z. Polley, Secretary ..... Joliet

TUESDAY MORNING, May 24
Old Chicago Room

To date the program for this section has not been received.

Public Relations Luncheon

TUESDAY, May 24
Louis XVI Room

12:00 "Impartial Medical Testimony," Judge Julius Miner

Section on Radiology

Bertil Roseberg, Chairman ..... Rockford
Abraham H. Cannon, Secretary ..... Chicago

TUESDAY AFTERNOON, May 24
Crystal Room

1:30 "The Pediatric Chest: Clinical and Roentgenological Evaluation"
Eugene F. Van Epps, Iowa City
Professor and Head of the Department of Radiology, University of Iowa College of Medicine

3:00 Recess to View Exhibits

3:30 Film Reading Session
Moderator: Eugene F. Van Epps, Iowa City

5:00 Business meeting and election of 1961 section officers

Section on Surgery

John B. Condon, Chairman ..... Chicago
Harold P. McGinnes, Secretary .... Bloomington

TUESDAY AFTERNOON, May 24
The Ballroom

1:30 Panel: "Advanced Breast Carcinoma"
Moderator: Robert L. Schmitz, Chicago
Panelists:
"Pathologist," James W. Henry, Stritch School of Medicine;
"X-Ray and Isotope Treatment," Eugene F. Lutterbeck, Chicago
"Hormonal Management," Paul V. Harper, University of Chicago
"Chemotherapy," Gerald McDonald, University of Illinois College of Medicine

3:00 Recess to View Exhibits

3:30 Panel: "New Concepts of Peptic Ulcer Management"
Moderator: Manuel E. Lichtenstein, Chicago
Panelists:
William J. Gillesby, Hines Hospital
Edward J. Foley, University of Illinois
Harry Oberhelman, Jr., University of Chicago
Morris Friedell, University of Illinois, Cook County Hospital

Section on Eye, Ear, Nose and Throat

Wiley H. Harrison, Chairman ..... Chicago
Wilbur W. Baumgartner, Secretary .... Kewanee

TUESDAY AFTERNOON, May 24
Gold Room 114

OPHTHALMOLOGY

1:30 "Devic's Disease"
Homer Field, Blue Island

1:50 "Some Practical Optics"
Paul Boeder, Ph.D., Iowa City
Associate Professor of Ophthalmology, State University of Iowa

2:50 Recess to View Exhibits

3:00 "Trends in the Care of Glaucoma"
Max Hirschfelder, Centralia

3:20 "Pharmacology of New Drugs in Ophthalmology — And Their Uses"
Peter C. Kronfeld, Chicago

3:40 "Movie on Eye Examination"
Eugene R. Fold, Skokie
or
"The Ocular Anatomical and Physiological Changes Due to Contact Lenses"
C. J. Black, Elmhurst

4:00 "National Medical Foundation"
Edward Albers, Champaign

Section on Anesthesiology

James Felts, Chairman ..... Marion
Freda B. Morgan, Secretary ..... Chicago

TUESDAY 3:30 P.M., May 24
Old Chicago Room

To date the program for this section has not been received.

PROGRAMS FOR WEDNESDAY, MAY 25

GENERAL ASSEMBLY

WEDNESDAY MORNING, May 25
The Ballroom

Michael E. DeBakey, head of the department of surgery, Baylor University College of Medicine, Houston, will deliver the Harold Camp Memorial Lecture during the morning session.

Section on Pediatrics

Homer F. Weir, Chairman ..... Rockford
Edmond R. Hess, Secretary ..... Evanston

WEDNESDAY MORNING, May 25
Crystal Room

9:00 "Massive Hemangioma with Secondary Thrombocytopenia"
Warren Greenwold, Urbana
The Carle Hospital Clinic

9:20 "Hypoglycemia in the Newborn"
Marvin Cornblath, Chicago
Sarah Morris Hospital for Children
Michael Reese Medical Center

9:40 "Hyperbilirubinemia in the Premature and Full Term Infant"
David Yi-Yung Hsia, Chicago
Children's Memorial Hospital

10:00 "Management of Animal Bites with Emphasis on Rabies Prophylaxis"
Karl Habel, Bethesda, Maryland
National Institute of Health

10:30 Intermission to View Exhibits
11:00 "Evaluation of Therapy in Purulent Meningitis"
Harold Spies, Chicago
Municipal Contagious Disease Hospital
11:20 "Management of Undescended Testes"
Orvar Swenson, Boston, Massachusetts
Surgeon-In-Chief, Boston Floating Hospital for Infants and Children
Dr. Swenson appears under the auspices of the Illinois Chapter, American Academy of Pediatrics
11:50 Business meeting and election of 1961 section officers
12:10 Luncheon with Illinois Chapter, American Academy of Pediatrics
The Old Chicago Room 101

GENERAL ASSEMBLY

WEDNESDAY AFTERNOON, May 25
The Ballroom

To date the program for this meeting has not been received.

Programs for Thursday, May 26

Section on Medicine

Charles A. Gianasi, Chairman ..... Chicago
Richard Allyn, Secretary ..... Springfield

THURSDAY MORNING, May 26
Crystal Room

To date the program for this section has not been received.

Section on Dermatology

J. M. McCuskey, Chairman ..... Peoria
Myron H. Kulwin, Secretary ..... Champaign

THURSDAY MORNING, May 26
Old Chicago Room

9:00 Chairman's Address
"Management of Skin Cancer by the Dermatologist"
J. M. McCuskey, Peoria
9:15 (To be scheduled)
9:30 Symposium: "Skin Disorders Due to Farming"
Director: Hans Buley, Champaign
"Actinic Dermatitis," Hans Buley, Champaign
"Allergic Dermatoses among Farmers," Malcolm Spencer, Danville
Assistant in Dermatology, Northwestern University Medical School
"Cutaneous Infections among Farmers," George Dickison, Peoria
"Eruptions Transferable from Animals to Man," D. Maksic, V.M.D., Assistant Professor of Veterinary Clinical Medicine, University of Illinois, Urbana
10:30 Intermission to View Exhibits
11:00 Round Table Panel: "Bacterial Infections of the Skin"
Chairman: Marcus R. Caro, Chicago
Consulting Dermatopathologist, Cook County Hospital
Panelists:
Harry F. Dowling, Chicago
Professor of Medicine and Head of Department University of Illinois College of Medicine
John T. Reynolds, Chicago
Clinical Professor of Surgery, University of Illinois College of Medicine
Stephen Rothman, Chicago
Professor and Head of the Section of Dermatology University of Chicago
12:00 Luncheon — Old Chicago Room 101 for members of the Section and guests
Business meeting and election of 1961 section officers.

Section on Allergy

Harold C. Wagner, Chairman ..... Chicago
Robert Becker, Secretary ..... Joliet

THURSDAY MORNING, May 26
Gold Room 114

To date the program for this section has not been received.

Section on Preventive Medicine and Public Health

Herbert Ratner, Chairman .....Oak Park
P. A. Steele, Secretary ..... Decatur

THURSDAY MORNING, May 26
Jade Room 103

9:00 a.m. PANEL: "The Present Status of the Polio Vaccines"
I. The Salk Vaccine
II. The Live Virus Vaccine
Moderator: Herbert Ratner, Oak Park
Herald R. Cox, Lederle Laboratories
Pearl River, New York
Bernard G. Greenberg, Chapel Hill
The University of North Carolina
Herman Kleinman, Minneapolis
Minnesota Department of Public Health

Paul Meier, The University of Chicago

11:00 a.m. Business session and election of 1961 section officers

11:15 a.m. Adjournment to view exhibits

12:00 noon: Luncheon, *The Orchid Room* 106
Section on Preventive Medicine and Public Health
Association of Medical Health Officers
Illinois Academy of Preventive Medicine
Illinois Chapter, American Association of Public Health Physicians
Open to all physicians
(Speaker — to be announced)

1:30 p.m. Adjournment in time for General Assembly in the Ballroom

Physicians' Association State Department of Public Welfare

THURSDAY MORNING, May 26
Room 107

Program material for this association has not yet been received.

ILLINOIS CHAPTER

American College of Chest Physicians

THURSDAY, May 26
The Ballroom

9:30 a.m. Registration

FIRESIDE CONFERENCES
10:00 a.m. — 12:00

NOTE: These conferences are informal and offer an opportunity for free discussion of many subjects of interest to all physicians. The discussion leaders will be seated at tables with proper identification. Physicians may participate in the discussion of their choice and may move on to other discussions when and if they desire.

1. Pediatric Cardiology
   Thomas G. Baffes, Chicago
   Donald E. Cassels, Chicago
   Joseph R. Christian, Chicago
   Benjamin M. Gasul, Chicago
   Bessie L. Lendrum, Chicago
2. Recent Advances in Coronary Disease
   V. Thomas Austin, Urbana
   Thomas J. Coogan, Chicago
   Chauncey C. Maher, Chicago
   Theodore Z. Polley, Joliet
3. Surgery in Heart Disease
   Egbert H. Fell, Chicago
   Ormand C. Julian, Chicago
   Peter V. Moulder, Chicago
   Laurence H. Rubenstein, Chicago
4. Pulmonary Function Testing
   Albert H. Andrews, Chicago
   David W. Cugell, Chicago
   Robert T. Fox, Evanston
   Ross C. Kory, Wood, Wisconsin
   Edwin R. Levine, Chicago
   Max S. Sadove, Chicago
5. Bronchospasm
   Paul H. Holinger, Chicago
   Morris A. Kaplan, Chicago
   George A. Saxon, Jr., Chicago
   Leon Unger, Chicago
6. Emphysema
   George S. Berg, Forest Park
   Benjamin Burrows, Chicago
   Robert W. Carton, Chicago
   William M. Lees, Chicago
   Gordon L. Snider, Chicago
7. Cor Pulmonale
   LeRoy Berard, Chicago
   Aldo A. Luisada, Chicago
   Irving Mack, Chicago
   John F. Perkins, Chicago
   Stanford K. Sweany, Chicago
8. Chemotherapy in Tuberculosis
   Meyer R. Lichtenstein, Chicago
   David F. Loewen, Decatur
   Karl H. Pfuetze, Chicago
   Herman C. Rogers, Mt. Vernon
   George L. Vernon, Edwardsville
9. Criteria for Home Treatment of Tuberculosis
   William R. Barclay, Chicago
   John J. Brosnan, Chicago
   Kenneth G. Bulley, Aurora
   Jerome R. Head, Chicago
   Eugene T. McEnery, Chicago
   David Reisner, Hines
10. Cancer of the Lung
    William E. Adams, Chicago
    Reynold J. Gottlieb, Hinsdale
    Hiram T. Langston, Chicago
    S. Allen Mackler, Chicago
    J. Robert Thompson, Chicago
11. Thoracic Surgery
    Edward E. Avery, Chicago
    Robert A. DeBord, Peoria
    George W. Holmes, Chicago
    R. Charles Oldfield, Jr., Oak Park
    Darrell H. Trumpe, Springfield
    Morris Zelman, Mt. Vernon
12. Pneumoconiosis
    Andrew L. Banyai, Chicago
    Irving M. Greenberg, Chicago
    Oscar A. Sander, Milwaukee, Wisconsin
    Eugene L. Walsh, Chicago
    John R. Winston, Chicago

12:00 Luncheon — Bal Tabarin, Hotel Sherman, Sixth Floor
"Carcinoma of the Esophagus"
Herman J. Moersch, Director of Medical Education and Research, American College of Chest Physicians; formerly Chairman, Section on Medicine, Mayo Clinic, Rochester, Minnesota

GENERAL ASSEMBLY

THURSDAY AFTERNOON, May 26
The Ballroom
To date the program for this meeting has not been received.

Programs for Friday, May 27

Section on Pathology

Franklin Moore, Chairman ..... Chicago J. R. Thompson, Secretary ..... Chicago

FRIDAY MORNING, May 27
Crystal Room
To date the program for this section has not been received.

Local Committees

Committee on Arrangements

General Chairman .....Andrew J. Brislen
Chicago
Vice Chairman ..... Roland R. Cross, Jr.
Chicago

Annual Dinner Committee

Chairman ..... Casper M. Epsteen
Chicago

William L. LeBoy
Sidney J. Shafer
Ralph J. Bailey
Norman J. Rose
Vernon L. Evans

Committee to Entertain Distinguished Guests

Chairman ..... Lee N. Hamm
Lincoln

Raleigh C. Oldfield
Allison L. Burdick, Sr.
Edwin F. Hirsch
George B. Callahan
Willard C. Scrivner
Paul A. Dailey

Publicity Committee

Chairman ..... Walter W. Murfin
Decatur

Charles J. Green
Morris T. Friedell
Marvin A. Rosner

Technical Exhibits Committee

Chairman ..... John P. Burgess
Rock Island

Lester S. Reavley
Donald E. Sloan
James H. Cross
Irving H. Neece

Women Physicians' Committee

Chairman ..... Eloise Parsons
Chicago

Lilly A. Rappolt
Janet Towne
Helen D. Heinen
Ella Sandberg
Cecelia Miller
Henrietta Herbolsheimer

Committee on Registration and Information

Chairman ..... Sanford A. Franzblau
Chicago

John S. Hyde
Warren W. Young
John D. McCarthy
Eugene Tsai
David T. Petty
Frank E. Nagel, Jr.
John B. Haeberlin, Jr.
Michael J. Kutza
Arvid A. Temple
Maurice F. Gleason
James H. Langstaff
Michael J. Lavin
William A. McNichols
Grover C. Otrich
Joseph E. Bourque
Edwin J. Lukaszewski
Nicholas J. Balsamo
Hubert L. Allen
Edwin G. Barton
Joseph E. Bellas
Francis E. Bihss
Milton E. Bitter
Carl Greenstein
Henry A. Hartman
Richard C. Powers
Murray E. Rolens
C. Paul White
Paul P. Youngberg

MEDICAL ECONOMICS



Medical Scholarships

Walter C. Bornemeier, M.D.

Cost, in time and money, is keeping our young people from studying medicine.

Thirty years ago, when a youngster left the farm to go to college, the only people whom he knew with a college degree were the preacher, the teacher, the doctor, the dentist and maybe a lawyer. Among these, the physician stood out because he was so often a friend in need and also because he was the first person in town to own an automobile.

Things have changed. Even the graduate of a small high school today knows about neutrons and jets. He knows about salesmen, ambassadors, industrial managers, and labor experts. He has heard about the forty hour week, unemployment insurance, social security, and retirement pensions.

What can we do to regain our fair share of the young people looking for a life's work? Two things seem to be immediately needed: recruitment programs and financial help. The House of Delegates of the AMA recently discussed both and a committee has been appointed to study these problems.

After graduation from college, a medical student needs $2,000 annually for four years in medical school. He also needs money for internship and residency, but the big money is the $8,000 required for the four years in school. This is where a scholarship would do the most good, to provide recruitment incentive and to make it financially possible to study medicine.

The doctors of Illinois, by each paying $20 per year, raise over $200,000 annually to aid medical schools. If we would raise a like amount for scholarships, we could give $1,000 a year to fifty freshmen, fifty sophomores, fifty juniors, and fifty seniors. With such a program, we could really go to the high schools and the colleges and have something attractive to offer to young people who want to study medicine, but who can't afford it.

This would be the best $20 annually that the doctor of Illinois has ever spent.

The richer years

In a philosophical mood, from time to time, I like to believe that even in the face of the atomic bomb and man's inhumanity to man, civilization is progressing—that it has removed itself at least a little distance from the savagery of the jungle. I like to muse that man has infinite capacities for self-enrichment and the translation of his abundant, developed talents into a noble service for his fellow men. I like to think that he can approach a stature and performance in fulfilling the rhythmic pattern of his life, conserving the basic harmonies to the period when, as his physical material seems to fade into insignificance, the emontional glow of his rich life should color his spiritual being. As one poet described another, "Behold him in the evening of his life. How imperceptibly he wears away, and yet like the sun, seems larger at the setting." *E. L. Bortz, M.D. Breaking Aging Barriers, Med. Ann. Dec. 1959.*

Council Meeting Minutes

THE regular January meeting of the Council was held at the Hotel Sherman, Chicago, on Sunday morning, January 31, 1960, with the following present: O'Neill, Hesseltine, Clark, Redmond, Adams, Reichert, Lull, Portes, Piszczek, Dooley, Endres, Reisch, DuPuy, Goodyear, English, Montgomery, Fullerton, Klein, Oldfield, Cannady, Sondag, Bettag, Hamilton, Compton, White, Limarzi, Sweeney, Mr. Neal, Mr. Oblinger, Mr. Mirt, Bennett, Reavley, Bornemeier, Scatliff, Fowler, and Frances Zimmer.

MOTION: (Fullerton-Piszczek) that the minutes be approved as mailed with one correction: The committee to make recommendations to the Governor relative to a replacement for Dr. R. R. Cross as director of the Department of Public Health was composed of Fullerton, Portes and Redmond. (Motion carried.)

Minutes approved as amended.

Dr. Montgomery introduced Dr. R. F. Sondag, assistant director of the Department of Public Health.

Report of President

Dr. Joseph T. O'Neill reported as president. He had attended few meetings since the last session of the Council. One was the meeting of the Advisory Committee on Oral Polio Vaccine. The meeting discussed the advisability of field trials for oral vaccine. It was an interesting session and the results will be of concern to all. Part of the problem mentioned at the last meeting of the Council dealing with psychiatric training in Illinois, has been answered by the new psychiatric hospital having been approved for residency training. Interest in postgraduate programs in Illinois, how they compare with programs in other states, plans for the future, etc., still concerns him. He feels that the Council should consider the development of something along this line.

MOTION: (Fullerton-Piszczek) that the report be accepted. (Motion carried.)

The president-elect had no report.

Report of Secretary

Dr. Lull reported as secretary. He had received a letter from Dr. Henry Krafft thanking the ISMS for membership in the Fifty Year Club and a letter from Mrs. Roland R. Cross acknowledging the resolution passed by the Council at the time of Dr. Cross' death. Dr. Lull informed the Council that the Chicago office was now covered under an insurance policy providing fire and extended coverage for equipment on hand.

Each member of the Council outside of Cook County has been asked to submit the names of physicians in most of the specialties, as well as the names of general practitioners, to develop panels for the use of the Court under the pro-

gram developed by the Committee on Impartial Medical Testimony. These names should be sent to the secretary (Suite 1909, 185 North Wabash, Chicago) so that panels can be developed in each Federal Judicial District, where this program is already in use. There are three judicial districts in the state and the importance of this activity cannot be stressed too highly.

MOTION: (DuPuy-Clark) that these panels be developed. (Motion carried.)

The councilors should consider carefully each individual when submitting his name. The Committee on Impartial Medical Testimony must screen these names again and have this information ready in the office in Chicago so that immediate service can be given any judge requesting such action. Dr. Lull stated that he would send a reminder to the downstate councilors.

Annual Meeting Committee

The Executive Committee considered several problems. The Committee for Programming the Annual Meeting has been appointed to serve as follows:

For three years
- Lorne Mason, Chairman, Evanston
- Walter Maddock, Chicago
- Harold Kolb, St. Joseph

For two years
- V. P. Siegel, East St. Louis
- George Byfield, Chicago
- William F. Mengert, Chicago

For one year
- Richard J. Bennett, Jr., Chicago
- Wright Adams, Chicago
- William DeHollander, Springfield

Ex-officio
- President, President-elect, Chairman of the Council and the Secretary. Also Chairman of the Committee on Arrangements.

The purposes of this committee are to develop and coordinate the general assemblies, the section meetings, and the scientific exhibits at the annual meeting.

The committee will recommend a secret committee to make the scientific awards to the Council.

The Council will arrange for the technical exhibits and the meeting places.

The Committee on General Arrangements (with appropriate sub-committees on the dinner, registration) will be appointed by the Council.

MOTION: (English-Fullerton) that the action be approved. (Motion carried.)

MS and PR

Dr. Hamilton reported as chairman of the Committee on Medical Service and Public Relations. The committee has serviced each county in the state on the Forand Bill and plans now to extend this campaign to the public and to other organizations. The question of timing is important, and efforts are being made to synchronize our program with that of the AMA and to coordinate our activity.

Bond Issue

The special committee (Hutton, Norbury, Sweeney) has reported its recommendations relative to the $150,000,000 bond issue as follows: The committee recommends approval of the proposed bond issue for use of the Illinois Department of Public Welfare for much needed new construction and major repairs in existing facilities. The committee also recommended favorable publicity in the Illinois Medical Journal and in direct contact with component societies. The Committee on Medical Service and Public Relations recommends that the Council concur, and that the Society favor the bond issue. It was suggested that effort be made to have funds already appropriated released and made available to Dixon and Lincoln, and that this matter be referred to the Committee on Mental Health.

MOTION: (Piszczek-Fullerton) that the Council approve these recommendations. (Motion carried.)

PR Luncheon Tuesday

The committee will have a joint luncheon on Tuesday noon, May 24, with the Committee on Impartial Medical Testimony. The details are not worked out, but activity will get under way.

Mr. Oblinger stated that he has been spending time in an all-out effort to combat the Forand Bill and similar legislation. Efforts are being made to contact other organizations outside of medicine and to get letters on the way to the congressmen. It is necessary that each physician "get involved" in this program; discuss the problem at service clubs, try to get resolutions passed by county societies, auxiliaries, various lay or-

ganizations, to kill the Forand Bill in committee. The Ways and Means Committee will be involved in other matters until the first of March, so February is left for us to work.

MOTION: (O'Neill-Fullerton) that the report be accepted. (Motion carried.)

Legislative Conference

There will be a meeting on February 28, for the purpose of discussing the Forand Bill. We had hoped to hold this meeting at the AMA headquarters building, but since this is impossible, we will have to find another place. The meeting will open at 9:30 a.m. During the morning there will be a coffee break, and the session will close at 1:00 o'clock. Perhaps a buffet luncheon can be scheduled at the end of the meeting. The question of an afternoon meeting is being considered.

Federal Aid to Education

A resolution has been sent out by the Illinois Chamber of Commerce relative to funds for educational construction, SB #8. The medical profession has approved a "one-shot" type federal grant but since this is not that type legislation, it is suggested that we join with the Illinois Chamber of Commerce in opposing the bill. Wires should be sent to both Senators—Dirksen and Douglas, asking opposition to SB #8 and similar legislation and that they vote against legislation of this type. A copy should be sent to the Chamber of Commerce.

MOTION: (Fullertion-Piszczek) so move. (Motion carried.)

Chicago Office

Dr. Leo Sweeney reported as chairman of the committee to recommend a location for the Chicago office.

The committee has had one telephone conference and two of the three members inspected a number of locations prior to a formal meeting of the committee on January 26.

Amount of space required: As both the Monmouth and Chicago offices occupy approximately 2,500 square feet each, it was the opinion of the committee that about 5,000 square feet would be adequate and would allow for expansion.

Accessibility: Consideration was given to accessibility to rail stations, CTA lines from both the perspective of the member and the employee; adequacy of public parking was also considered. Air conditioning was a "must."

Rental at the present time is as follows:

Chicago	$700.00
Monmouth	219.00
	$919.00

and with an estimate of about 4,565 square feet, this amounts to $2.42 per square foot per year. Other items considered were the physical aspects, the lighting, the floor layout, the cost of alterations (one place we were told it was 5% of the term rental), tenure, etc. The Council must take into consideration the fact that it will take from 30 to 120 days to prepare the office for occupancy depending upon the amount of alterations necessary.

The lease on the present office in Chicago expires May 1; there is no lease on the Monmouth office, so it is presumed that 30 day notice is all that is needed.

The committee recommends the selection of the office space available at 360 North Michigan (the London Guaranty Building). The space is adequate; location near the loop; transportation good; parking nearby; air conditioning already available; meals could be served in the office for meetings by the London House. The rental is approximately $5.00 per square foot, and the space is available April 30. The Chicago office could move May 1 and the Monmouth office June 1. The space is located on the 20th floor.

MOTION: (English-O'Neill) that we accept the recommendations of the committee and that the officers negotiate for the proper lease (five years) to take care of the future location of the administrative office of the Society. (Motion carried.)

MOTION: (Portes-Fullerton) that the report be accepted. (Motion carried.)

Birth Certificates

Dr. DuPuy reported as chairman of the Committee on Birth Certificates. A meeting was held with Mr. E. L. Wittenborn of the Department of Public Health to consider the new form for the recording of births in Illinois. New legislation should also be introduced to assist in shielding portions of the certificate from the public. Copies of the new form were distributed for the information of the councilors.

Motion: (Portes-Piszczek) that the new form be approved by the council. (Motion carried.)

Committee on Aging

Dr. E. W. Cannady presented the report of the Committee on Aging. Council approval is requested to endorse and co-sponsor a symposium on the treatment of the stroke patient to be held on Monday, May 23, just prior to the opening of the state meeting.

Motion: (Endres-Fullerton so move. (Motion carried.)

The chairman of the committee has been invited to participate in the 1960 National Health Forum on "Positive Health in Older People" to be held in Miami Beach, March 14-17.

Motion: (Portes-Fullerton) that the chairman accept the assignment and attend the meeting as the representative of the ISMS. (Motion carried.)

The Illinois Joint Council to Improve the Health Care of the Aged met in Springfield on January 16. A new constitution was drafted which should be approved by all participating groups — Illinois Nursing Home Association, Illinois Hospital Association, Illinois State Dental Society, and the ISMS. A copy has been filed in the secretary's office and Dr. Lull attended the meeting in Springfield and is familiar with the material.

Motion: (English-O'Neill) that the C & B L be approved. (Motion carried.)

Constitution and By-laws

The question of the division of the Committee on Medical Service and Public Relations has already been referred to the committee for study and to develop material for the House to consider.

Dr. Bornemeier discussed the problem of a "presiding officer and assistant presiding officer" for the House, his duties, his responsibilities, and the various thinking expressed by the members of the Council, the reference committee and the House of Delegates. Various opinions were expressed by members of the Council and by members of the Committee on Constitution and By-Laws. The committee agreed that material would be prepared and checked by the attorneys so that it could be considered by the House in May. A general revision of the entire by-laws may be necessary, but not too many changes in the constitution itself seem warranted.

Motion: (English-Portes) that the matter be considered in the light of suggestions developed by the House and the necessary portions of the constitution and/or by-laws prepared for the action of the House in May. (Motion carried.)

White House Conference

Dr. Henry Ricketts, a member of the committee, will represent us on the research committee dealing with preliminary work on the White House Conference. Each county survey will determine the needs existing therein; there will be regional meetings, and all county societies should be alerted so that of the 100 delegates from Illinois, as many as possible will be physicians.

Dr. Bornemeier reported as chairman of the Committee on Constitution and By-Laws and outlined for the Council some of the proposed changes suggested by the House at the special meeting on the 13th of December.

Harold M. Camp Memorial

Dr. O'Neill stated that the committee (O'Neill as chairman, English and Reisch) had considered the matter of a suitable memorial for Dr. Harold Camp. There were various things considered — a scholarship at his alma mater; a lecture at Northwestern, etc., but since all his interests were centered in the State Society over so many years, it was the opinion of the committee that a memorial lecture to be given during the annual meeting each year, should be developed in his honor. The committee felt that plenty of leeway should be given as to where, what, when, who, etc. The lecture could be scientific if given before the general assembly; it could be of an economic nature, before the House of Delegates; it might be presented at the annual dinner, etc. An honorarium will be attached to this honor.

Dr. English stated that he talked to Dr. Hammond (JAMA) and to Dr. Blasingame about this proposed action, and asked if the JAMA might publish the paper at the time of the presentation, if it were of sufficient stature. They agreed to cooperate and to consider this action seriously. The home office of the AMA is Chicago; we can get its help and cooperation and

this seemed a good line of approach.

Dr. Reisch stated that this type lecture kept the activity within the realm of the State Society where Doctor Camp's interests were centered, and where he probably would prefer to be honored.

Dr. O'Neill asked for an expression of opinion relative to the selection of Dr. White to present the first Harold M. Camp Memorial Lecture.

MOTION: (O'Neill-Fullerton) that the Council concur and that the Harold M. Camp Memorial Lecture become a feature of the annual meeting each year, and that the chairman of the Council at the organization meeting of the Council, appoint a committee to implement and develop this lecture annually. (Motion carried.)

Job Specifications and Personnel

Dr. Hopkins reported as the chairman of the Ad Hoc Committee on Job Specifications and Personnel. Two positions were to be filled. (1) an executive administrator, and (2) a public relations director. The committee has had material from 85 people for the administrative position and has now narrowed it down to four — one an administrator for the Boy Scouts of America; one an executive director of a state Chamber of Commerce; one a young man who is administrator for a county society in the western part of the country, and the fourth, an executive director for a national organization also located in the west, although the man himself is an easterner. He has had medical society experience. This fourth candidate will be in Chicago to meet with the committee next Saturday. Incidentally only one physician has applied for the position.

The committee has screened 42 individuals for the position of public relations director, and approximately three are very promising material. However, it was the feeling of the committee that the new executive director should have something to say about who is employed to take over the public relations work, and, therefore, it was the committee's recommendation that no action be taken along this line as yet.

The question of interviewing the applicant for the executive position was discussed. The Council was asked if a special meeting should be held, or if the responsibility of employing the individual should be left to the Ad Hoc Committee and the Executive Committee and/or the Policy Committee.

MOTION: (English-Dooley) that the Executive Committee be empowered to interview and to hire an executive director following recommendation by the special Ad Hoc Committee. (Motion carried.)

The Executive Committee was asked to meet at the Chicago office, 185 North Wabash, next Sunday morning, February 7, at 9:00 o'clock, at which time the gentleman in question will be available for an interview. The biographic material is to be submitted to the Executive Committee as soon as possible. A contract with the applicant was discussed; the question of having Dr. Lull remain as long as possible also was discussed. Dr. Lull stated that he should leave by April 1 according to present arrangements.

MOTION: (English-Piszczek) that Dr. English, Coleman and Dr. Hamilton see Dr. Lull's new employer to arrange if possible for him to remain with the State Society until June 1. (Motion carried.)

Director, Public Welfare

Dr. Bettag reported as Director of the Department of Public Welfare. He thanked the Council for the action approving the $150,000,000 bond issue requested by his department. Other organizations have also approved the issue — Illinois Chamber of Commerce, the Illinois Nurses Association, the Public Health Association, etc.

West Suburban Hospital has developed an affiliation with the Chicago State Hospital and it is hoped that this will be of mutual benefit. The psychiatric residency program is going along very well, some 30 residents are under the program, and some 100 applicants are on file. The child psychiatric program is also progressing well, and has full approval.

The Governor contacted the committee appointed by this Council to assist in screening the names of applicants for the position of Director of the Department of Public Health, and he appreciated the interest and the cooperation.

The nursing program developed by the department has had some 750 students and some 250 have come to work for the Department. About 200 are under the program now, and the nursing situation is better than it has ever been in the history of the department. Salaries have

been adjusted; for a physician there is a top salary of $20,000, and for nurses a top salary of $12,000.

The Russian group touring this country as an exchange group resulting from the visit of the various governors to Russia will be in Chicago next Saturday afternoon. They will tour Illinois Psychiatric Institute for about an hour. Members of the Council are invited.

Illinois Pediatric Institute is under construction and will be open in 1961. It will accommodate some 500 mentally retarded children under five years of age. Personnel for this new hospital is needed, and many individuals are already under consideration.

MOTION: (Piszczek-Fullerton) that the report be accepted. (Motion carried.)

MOTION: (Piszczek-Fullerton) that Frank Fowler be authorized to plan the luncheon given by the Illinois Society at the AMA meeting in Miami. (Motion carried.)

Academy Rating

Dr. Lull reported that categorical classification for the ISMS annual meeting cannot be secured from the Academy of General Practice until after the program is completed for consideration.

He also reported that insurance had been taken out (public liability and property damage) which will cover the Society during the year, and with special coverage during the annual meeting at the hotel.

MOTION: (Dooley-Reisch) that this be approved. (Motion carried.)

Interprofessional Council

The matter of membership in the Interprofessional Council was discussed and the action of the House of Delegates considered.

MOTION: (Portes-Clark) that a special committee be appointed to study and report back to the Council at the March meeting its recommendations relative to again joining the Interprofessional Council. (Motion carried.)

Dr. Montgomery appointed the following committee: Dr. Piszczek, chairman; Dr. English; and Dr. Clark.

Stamp Exhibit

Dr. Lull outlined Mr. Mirt's exhibit on stamps of special medical interest. The exhibit has been developed by Mr. Mirt personally, and it might prove of interest at Miami for the AMA meeting.

MOTION: (English-Dooley) that Mr. Mirt be sent to Miami in order to have this exhibit available for AMA showing. (Motion carried.)

AMA Chairman

Dr. Lull reported that the AMA had approved the appointment of Dr. Walter C. Bornemeier as general chairman of the Committee on Arrangements for the AMA meeting in Chicago in 1962.

National Foundation Scholarships

MOTION: (English-Piszczek) that the Chairman of the Council appoint three individuals whose names are to be submitted to the National Foundation, one of whom will serve on the committee to select candidates for medical scholarships under the extended program of the Foundation. (Motion carried.)

Rural Health Meeting

MOTION: (Hesseltine-Endres) that either Harlan English or some physician from his Committee on Rural Health, attend the meeting of the AMA group at Grand Rapids, February 25-27. (Motion carried.)

Emeritus and Retired Members

MOTION: (Piszczek-Reisch) that the Emeritus members be elected as listed. (Motion carried.)

Jones, Clarence K., 1201 Chase Avenue, Chicago, C. M. S.

Vehe, Karl L., 1943 Lunt Avenue, Chicago, C. M. S.

Wilson, Uthie R., 417 N. Water Street, Decatur, Macon

MOTION: (Fullerton-Piszczek) that the Retired Members be elected as listed. (Motion carried.)

Cassidy, George P., 4 S. Genesee, Waukegan, Lake

Bergstrom, Paul L., Kirkland, Dekalb

Fradkin, Morris K., 602 N. Central Avenue, Chicago, C. M. S.

Miller, Fred M., 2136 Indiana Avenue, Chicago, C. M. S.

Sequin, Arthur C., 9202 Grove Avenue, Des Plaines, C. M. S.

Waldmann, Louis F., 4 S. Genesee Street, Waukegan, Lake

MOTION: (Reisch-Fullerton) that the bills as audited by the Finance Committee be approved. (Motion carried.)

Public Health Award to Cross

Dr. Lull reported that Mrs. Zimmer had suggested that, as a member of the Illinois Public Health Association, the form nominating a recipient for the annual award of recognition in the field of public health, be filled out requesting this honor posthumously for Dr. Roland R. Cross.

MOTION: (Piszczek-Fullerton) so move. (Motion carried.)

Veterans' Meeting

A letter has been received from the Indiana State Medical Society asking that Illinois participate in a regional meeting dealing with Veterans Affairs on the 27th of September. The executive committee approved meeting with this group, and suggested that the new Council select the represenatives.

Postgraduate Education

Since October 1959, we have secured 43 speakers for county societies, and have given speaker service to 20 counties and two branches of the CMS. Some 1,771 double postcards have been mailed, and 349 single postcard notices sent out. A total of 333 news releases have gone out.

Since February, 1958 approximately 85 additional names of physicians willing to present scientific programs have been received. These have been arranged according to category and mimeographed on loose leaf sheets so that they can be added to the "List of Speakers" and sent to program chairmen of county societies.

Radio program, "Your Health Comes First", over Chicago station WJJD has been scheduled as follows:

January — "The Common Cold"
February — "Diabetes"
March — "Bursitis of the Shoulder"
April — "Diagnosis of Cancer"

Thirteen speaking appointments were arranged for lay groups. These included parent-teacher associations, various service clubs and church organizations and the Fifth Army personnel officers.

Of the three postgraduate conferences requested, so far the date and final information has been received on only one. There are no details on the other two.

MOTION: (Fullerton-Endres) that the report be accepted. (Motion carried.)

Impartial Medical Testimony

Dr. Bennett stated that he was reporting for Dr. Levinson, chairman of the new Committee on Medical Testimony. The future of this activity in Illinois depends upon the success of the program in Federal court, and on the ability of the committee and members of the profession to sell the idea to the district and local judges. There is a heavy backlog of cases piled up in District courts and it is possible to have impartial medical testimony used as a means of clearing up a lot of these "holdovers."

We should have resolutions from specialty societies approving impartial medical testimony. The resolutions would be helpful in publicizing this program among the judges and lawyers outside of Cook County especially. The Supreme Court of the State has the power to put this program into effect if it sees fit. It is most important that the panels be ready and available for use if and when the request is received.

The committee requests the Council of the Illinois State Medical Society to ask each Councilor outside of Cook County to prepare a screened panel of experts in his district.

The committee desires to cooperate with the Committee on Medical Service and Public Relations in holding the special luncheon on Tuesday, May 23, during the annual meeting. At that time it will have been six months since the program was started in Illinois, and this gives us an opportunity to present material which should provide good publicity.

English stressed the importance of personal contact with all people interested and concerned with this program in the downstate area. Dr. O'Neill called the attention of the Council to an article which appeared either in the November or December issue of Postgraduate Medicine which dealt with the question at hand.

MOTION: (Piszczek-Fullerton) that the report be accepted. (Motion carried.)

Motion: (Fullerton-Endres) that the officers of the state medical societies (Iowa, Kentucky, Missouri, Wisconsin, Michigan, Indiana) be invited to attend the annual meeting. (Motion carried.)

Montgomery stated that the Ad Hoc Committee to find office space for the headquarters' office in Chicago had completed its work and was hereby dismissed.

School Health

Dr. Fullerton stated that the Committee on School Health had met on Saturday, January 30, but that the report would not be given until the March meeting of the Council.

He read a proposed letter thanking the Governor for his cooperation and consideration in the appointment of Fatheree as director and Sondag as assistant director of the Department of Public Health.

Motion: (Fullerton-Reisch) that the letter of appreciation be sent. (Motion carried.)

Since the wok of the committee has been finished, it was dismissed by the chairman.

Cancer Meeting

Dr. Lull stated that the executive committee recommended that the officers and the Chairman of the Cancer Control Committee attend the first Illinois Congress on Cancer to be held in Springfield March 9, 10, 11.

Motion: (Piszczek-Reisch) so move. (Motion carried.)

Over Sixty-five

Dr. Hesseltine reported as chairman of the committee to study and recommend on a fee structure for those over 65 years of age with limited income and net worth. This committee is composed of A. L. Burdick, Sr., Fred H. Decker, R. E. Heerens, Harry Mantz, E. L. Strohl, and Hesseltine. The committee met on two different Wednesday afternoons in the month of January. There has been 100% attendance. The committee recommends that income ceiling and net worth level for service policy coverage be set as follows:

For a couple — $3,000 total annual income
For an individual — $2,000 total annual income

Net worth ceiling was established:

For a couple — $20,000
For an individual — $15,000

Motion: (Piszczek-Fullerton) that the Council approve these recommendations. (Motion carried.)

Dr. Hesseltine stated that the committee met on its last meeting with representatives of the Blue Shield Plans in Illinois (Mr. Clark and Dr. Boswell from Rockford and Mr. Evans, Mr. Lowe, and Dr. Troxel from Chicago). Considerable discussion ensued about various questions and matters, both during and following the presentations of the views by the respective plans. Mr. Clark proposed a plan which would have a maximum surgical benefit of $300.00. The premium rate would be $31.68 yearly for 30-day hospitalization. The Plan proposed by Mr. Evans was the general certificate, which has a $200.00 maximum surgical benefit schedule for 30 days. The rate would be approximately $24.00 ($23.85-$24.15) yearly* for 30-day hospital stay for medical-surgical coverage. Mr. Clark emphasized that the doctors would have better benefits and therefore could be more easily convinced to cooperate.

Mr. Evans expressed the concern that the public and the news media would not differentiate between the indemnity and service plans. Thus, any plan with higher benefits might lead to damaging adverse publicity. It has been estimated that about 47% of the people in Illinois over age 65 have incomes of $1500 yearly or less. The committee recognized the merits and limitations of both proposals. The committee agreed by a majority opinion to present both plans to the Council. The committee recognized that the Council may refer the matter back to the committee: (1) with or without instructions, (2) that it may approve of either or both of these plans, and (3) that it may take the matter away from the committee and decide the matter in its own judgment. Your commitee was of the opinion that those over 65 should have immediate consideration.

Dr. English called attention of the Council to the fact: that the House of Delegates' December meeting asked the Council to develop a fee structure and submit it to the membership for each doctor's consideration. In the ensuing discussion it was stressed that the lowest premiums

*Since the Council meeting this rate has been reduced to $19.80.

should have an appeal for those with limited means. Dr. English commented that (1) the general certificate benefits of the Blue Shield Plan of Chicago are known, (2) that the premium rate is the lowest, (3) that the Illinois Medical Service Plan as proposed by Mr. Evans was prepared to adequately underwrite the promotion if it was requested to be the fiscal agent, and (4) that one plan seemed necessary to eliminate confusion to the public and profession, and to avoid undesirable news media reports.

Hesseltine asked who was to determine the net worth of the individual. It was the opinion of the Council that the physician was the best guide in this matter, and his statement should be accepted.

Montgomery stated that it had been discussed that each county medical society have a committee to which the insurance agent can go to discuss this problem.

MOTION: (Piszczek-English) that we accept the report of the committee and the Illinois Medical Service plan as outlined. (Motion carried.)

MOTION: (English-Portes) that the Council authorize Dr. Lull to contact Mr. Robert Evans to inform him that the Council has approved the proposed Illinois Medical Service contract, and that it be implemented in the usual manner. (Motion carried.)

Dr. Montgomery stated that the committee was to be held on a "standby" basis until these functions get underway.

Sondag re Public Health

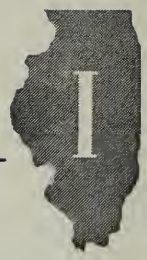
Dr. R. F. Sondag, assistant director of the Department of Public Health reported that he was pleased to attend the council meeting in his official capacity, and he regretted that Dr. Fatheree had not been able to be present. Dr. Sondag stated that he had always been interested in the ISMS, had served his own county medical society (Jackson County) as secretary in the past, and assured the members that his interest would continue in the future. Either he or Dr. Fatheree would plan to be present at all Council meetings, and he assured the Council that the cooperation of the Department would continue as it had under the leadership of Dr. Cross.

The Council adjourned at approximately 3:00 o'clock. All councilors desiring to do so went to 360 North Michigan Avenue to see the new offices of the Society in the London Guaranty Building.

The next meeting of the Council will be held on Sunday, March 13.

Respectfully submitted,
GEORGE F. LULL, Secretary

ANNOUNCEMENTS



April clinics for crippled children

A special clinic for children with cardiac conditions, two for those with rheumatic fever, and one for cerebral palsied children are among the 23 clinics for Illinois physically handicapped children scheduled for April. Eighteen general clinics will also be held by the University of Illinois, Division of Services for Crippled Children. They will provide diagnostic orthopedic, pediatric, speech, and hearing examinations along with medical, social, and nursing services. Clinicians are selected from among private physicians who are certified Board members.

Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

April 1 — Chicago Heights (Cardiac), St. James Hospital
April 5 — Quincy, Blessing Hospital
April 6 — Alton (Rheumatic Fever), Alton Memorial Hospital
April 6 — Hinsdale, Hinsdale Sanitarium
April 7 — Cairo, Public Health Building
April 7 — Flora, Clay County Hospital
April 8 — Evanston, St. Francis Hospital
April 12 — East St. Louis, St. Mary's Hospital
April 12 — Peoria, Children's Hospital
April 13 — Champaign-Urbana, McKinley Hospital
April 14 — Springfield, St. John's Hospital
April 19 — Belleville, St. Elizabeth's Hospital
April 19 — Danville, Lake View Hospital
April 20 — Chicago Heights (General), St. James Hospital
April 21 — Bloomington A.M. (General), P.M. (Cerebral Palsy), St. Joseph's Hospital
April 21 — Elmhurst Cardiac, Memorial Hospital of DuPage County
April 21 — Rockford, Rockford Memorial Hospital
April 26 — Effingham (Rheumatic Fever), St. Anthony Hospital
April 26 — Peoria, Children's Hospital
April 27 — Carrollton, First Baptist Church
April 27 — Elgin, Sherman Hospital
April 28 — Mt. Vernon, Masonic Temple

Community cancer control projects

A fund of $1,500,000 appropriated by Congress this year has been earmarked for community cancer demonstration projects. It is being administered by the Cancer Control Program, Bureau of State Services, Public Health Service, under guidance of the director of the National Cancer Institute. Projects should demonstrate better ways of providing community cancer control services through application of existing knowledge. Locally-sponsored and locally-directed

projects will be considered on their own merits. Applications are accepted from nonprofit organizations and institutions and official health agencies. Initial approval may be for as long as three years. Additional information and application forms may be obtained from the regional offices of the Public Health Service, Chicago.

Course in neuromuscular diseases

The Cook County Graduate School of Medicine announces a two-week intensive course in Neuromuscular Diseases of Children with Special Emphasis on Cerebral Palsy, to be given by Dr. Meyer A. Peristein June 20 to July 1. The course, designed for pediatricians, orthopedists, neurologists, psychiatrists and physiatrists, emphasizes the practical clinical aspects of treatment and rehabilitation procedures. It will include trips to demonstration clinics and treatment centers. The fee is $250, and since registration will be limited, applications should be made as far in advance as possible. For further information, write to John W. Neal, Registrar, Cook County Graduate School of Medicine, 707 S. Wood St., Chicago.

Course in Clinical Pathology

The Frank E. Bunts Educational Institute of the Cleveland Clinic Foundation and the Cleveland Society of Pathologists will offer a postgraduate course entitled "Clinical Pathology" March 31 and April 1 in the North Clinic Building. Most of the faculty are drawn from the Foundation, and all are from Cleveland. Registration fee is $25, and may be sent to the Education Secretary of the Institute, 2020 E. 93rd St., Cleveland 6.

College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists will hold its annual meeting at the Netherland Hilton Hotel, Cincinnati, April 3-6.

New this year will be the correlated seminars, each consisting of four sessions spread over three days, all devoted to the same subject under the same leader. There will be a panel discussion Tuesday morning on medical service plans, with representatives of industry, labor, insurance, and medicine speaking on third-party plans. The presidential address will be delivered by Dr. John I. Brewer, Chicago. The reception and dinner dance will be held Tuesday evening.

Dr. C. Paul Hodgkinson, Detroit, will be installed as president.

For further information write to Mr. D. F. Richardson, Executive Secretary of the College, 79 W. Monroe St., Chicago 3.

Courses in prosthetic education

The only courses in prosthetic education in the Midwest are being sponsored by Northwestern University Medical School under a grant from the Office of Vocational Rehabilitation, Washington, D. C. Course No. 613, "Below-Knee Prosthetics for Physicians and Surgeons," will be given May 16-20; Course No. 603, "Above-Knee Prosthetics for Physicians and Surgeons," June 13-17.

Traineeships covering tuition and transportation are available to physicians for these courses. Applications for them and for enrollment may be requested from: Director, Prosthetic Education, Northwestern University Medical School, 401 E. Ohio St., Chicago 11.

Camp for diabetic children

The summer camp for diabetic children will be conducted for the twelfth year under the auspices of the Chicago Diabetes Association from July 17 through August 7 at Holiday Home, Lake Geneva, Wis. Boys and girls 8 through 14 years of age are eligible. Rates are arranged to fit individual circumstances.

As in previous years, the camp will be staffed by resident physicians, a nurse, two dietitians, and a laboratory technician in addition to the regular counseling and domestic staff.

Applications may be obtained from, and inquiries should be directed to, the Chicago Diabetes Association, 5 S. Wabash Ave., Chicago 3.

Another invitation to Hawaii

The eighth Congress of the Pan-Pacific Surgical Association will be held in Honolulu, September 27-October 5. Ten surgical specialty sections will be held simultaneously.

All members of the profession are eligible to register and are urged to make arrangements as soon as possible to obtain adequate facilities.

For further information write to Dr. F. J. Pinkerton, director general of the Association, Suite 230, Alexander Young Building, Honolulu 13.

Congress of physical medicine

The Third International Congress of Physical Medicine will be held August 21-26 at The Mayflower, Washington, D. C. A copy of the preliminary program containing detailed information may be had on request by writing Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 N. Michigan Ave., Chicago 2.

ACS Clinical Congress Date

The American College of Surgeons announces that a previously announced date for the Annual Clinical Congress should be changed to October 10-14. The meeting will be held in San Francisco. Address inquiries to Dr. William E. Adams, Secretary, ACS, 40 E. Erie St., Chicago 11.

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Tools of the trade

Perhaps you have heard the story of the young M.D., just starting practice, who was called to the telephone to hear an excited voice say, "Doctor, come over quick and see my wife. I think she has tonsillitis!" The young doctor grabbed his bag and hurried off. He was shown to the wife's bedroom by the husband who began pacing up and down before the closed door. After about ten minutes the doctor opened the door and said, "I'm awfully sorry to trouble you, but could you find me a long wire with a hook on the end?" The husband got such a wire and continued his pacing. About five minutes later the door again opened and the young doctor asked, "Could you possibly get me a large pair of pliers?" The husband produced the pliers and again took up his vigil. After a few minutes the door opened again and the doctor said, "Sorry to bother you but could you get me a ball peen hammer?" The husband goth the hammer and when he handed it to the doctor said, "Could you please tell what's wrong with my wife?" "I don't know yet," said the young M.D., "I haven't been able to get my bag open!" *Frederic C. Schreiber, M.D. Surgical Gambits. Harper Hosp Bull. Nov.-Dec. 1959.*

THE P. R. PAGE

John A. Mirt

Letters hold fate of Forand Bill

Letter writing (may) determine the fate of the Forand Bill. Representatives in Congress must be convinced that the public wants no part of this program, which is another step toward socialized medicine.

Congressmen may not read thoroughly every piece of mail sent to them but they do scan letters to determine the views of their constituents. They keep a tally of opinions for or against a pending measure, and frequently are guided by the totals.

The greatest weight is placed upon individually written communications from constituents and from local groups. Signed forms or petitions usually are ineffective.

The volume of letters from the friends of medicine concerning the Forand Bill must be stepped up between now and the time the measure comes before the House for vote. Concentrated activity at county levels is necessary to accomplish this.

Exhibits at a county fair

This is the time of the year to consider an educational display at the local county fair, usually scheduled for September or October. The first step is to ascertain if space is available. The next is to plan the exhibit.

Considerable helpful material is obtainable from the AMA. Appropriate literature is available for distribution. Exhibits of public interest also can be supplied.

Each year, the Illinois State Medical Society has sponsored an exhibit at the state fair in Springfield. These have been most successful from a public relations standpoint. For helpful tips, write Dr. Jacob E. Reisch, 1129 South Second Street, Springfield, who has arranged the showings.

Service at a reasonable price

The AMA considers that there has been weakness in medical efforts to communicate to the public the true story on medical costs. As a result, the opinion has developed that physicians are excessively money-minded, that they charge a lot more than justified, and that they do not keep charges as low as possible.

Needed, the AMA believes, are: (1) greater widespread educational efforts on medical care costs in relation to other costs; (2) promotion of medicine's traditional guarantee to provide medical care to all, regardless of ability to pay, whether these plans are formal or informal; (3) development of relative value studies as recommended by the AMA House of Delegates; (4) continued education of individual physicians on the importance of itemizing medical bills, initiating advance fee discussions, and cutting costs for patients where possible; (5) increased emphasis on using and not abusing health insur-

ance plans, and on the promotion of wider insurance coverage.

Signs of the times

Some county societies are furnishing members with cards to be posted in the reception room or on office door to explain that the physician is attending a medical meeting to further his medical education. This can have a two-fold benefit: (1) improve physician-patient relationship; (2) boost attendance at medical meetings.

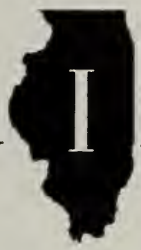
A county society in Pennsylvania carried an announcement in the local newspapers calling attention to the fact that "medical men need vacations, too." It went on to describe the arrangements made by members of the society to guarantee that patients will have adequate emergency medical care during absences. The society's emergency call number was listed.

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Hypotheses on serum cholesterol levels

It has not been finally established whether the effectiveness of vegetable oils (such as corn oil) in lowering the level of serum cholesterol is caused by a specific chemical effect of its unsaturated fatty acids or whether the effect is instead a replacement of other materials, e.g., saturated fatty acids which are positive causes of hypocholesterolemia. Horlick has shown in human subjects that the addition of corn oil to low fat diets which had already reduced the serum level of cholesterol would not further depress the cholesterol level. These data and others like them suggest that corn oil acts in a substitutive or neutral way, replacing some noxious and presently unidentified material. It is very clear that simply adding a few tablespoons of vegetable to the usual diet will accomplish nothing. This will disillusion the easy dieters. It must also be apparent that the American diet is, and has been for several decades, abundant in the vegetable oils, and these are the rich sources of unsaturated fatty acid. Vetgetable oils, corn, cotton, and peanut oils are rich in the so-called essential fatty acids. It is inconceivable that Americans could develop unsaturated fatty acid deficiency. The contention of Sinclair that this deficiency is a relative matter, a disproportion of saturated and unsaturated fatty acids, is difficult to answer, but it is significant that no direct feeding experiments have demonstrated the relationship. There are two interesting, if remote, possible explanations of the action of unsaturated fatty acids on the serum cholesterol level. The effects could be mediated through an induced loss of sterols via the bowel, a kind of steatorrhea induced by unsaturated fatty acids and not so by saturated fatty acids. If this were true, the vast preoccupation with unsaturated fatty acids would become the greatest unpremediated study of catharties and laxation ever undertaken! *George V. Mann, M.D. A.M.A. Arch. Intern. Med. Dec. 1959.*

AT THE EDITOR'S DESK



Pharmaceuticals

Pantho-Foam (aerosol) is U. S. Vitamin's new hydrocortisone pantothenylol aerosol ointment. The corporation recommends it for the prompt relief of pain in burns and traumatic lesions, along with relief of itching in atopic and contact dermatitis as well as pruritic lesions of the anus and vulva.

Desitin HC hemorrhoidal suppositories contain hydrocortisone, cod liver oil, lanolin, zinc oxide, bismuth, and balsam peru in a cocoa butter base. Desitin Chemical Company recommends it for severe inflammatory anorectal conditions.

Quinaglute Dura-Tab S.M. (Wynn) contains 5 grains of quinidine gluconate in a new sustained-action tablet. It has the same indications and contraindications as other quinidine products.

A sublingual ergotamine tablet (Ergomar) is now available for migraine. It dissolves under the tongue within a few seconds and is recommended for its convenience. The drug was tested on 31 patients; 21 reported excellent results and four obtained partial relief of headache.

A question of viewpoint

Is alcoholism a disease or a moral weakness? Vincent Tracy, a reformed frequenter of skid-row who operates a rehabilitation center for excessive drinkers called Tracy Farms at Coeyman's Hollow, N.Y., believes in the latter view. He was so quoted last November in the Robert Peterson column appearing in the New York Journal American. The National Council on Alcoholism came back promptly with a news release to the contrary complaining that Tracy used an outdated, unscientific, and potentially dangerous viewpoint.

It points out that Mr. Tracy's opinions are in opposition to those of eminent scientists as well as national, international, and state professional organization which have recognized alcoholism as a disease. Mr. Tracy's methods of approach to the alcoholic, the NCA contends, are "a potpourri of group therapy, psychodrama, and the techniques developed and applied over the past 25 years by Alcoholics Anonymous;" that not all alcoholics respond to this treatment alone; some need counsel and treatment by physicians and therapists. It points to thousands of alcoholics thus rehabilitated.

Mr. Tracy maintains that the disease concept offers the alcoholic an excuse, an easy out, for excessive drinking.

The NCA objects to the one-sided presentation in Peterson's column of a "maverick-minority opinion" for reader consumption and fears a breakdown of helpful public attitudes toward the alcoholic built up over the last 15 to 20 years. "If the alcoholic thinks of himself as a moral weakling, he—and his family—will be ashamed to seek available help; if he accepts the concept that he is a victim of a treatable disease, he will take advantage of resources that help him recover," i.e., the 3000 hospitals admitting alcoholics and the programs developed by both states and industry.

Now stereotactics for surgery

The United Cerebral Palsy Association is beginning to send out news releases that advise, "Brain surgery, employing improved instruments now being developed through research, may provide hope for many cerebral palsied children who are otherwise fated to be severely crippled or bedridden for life." They refer the readers to Dr. Yale David Koskoff at the Montefiore Hospital Institute of Research, Pittsburgh. He has the stercotactic apparatus that enables the surgeon to precisely pinpoint his operative target. He is able to eliminate those areas of the brain that produce the uncontrolled spasms and violent writhing.

How do you like that?

If you suddenly lose an old cerebral patient you'll know where he went.

Dr. Sabin to study cancer viruses

Dr. Albert B. Sabin, Cincinnati's world renowned expert on viruses, has received a grant of $611,800 from the U. S. Department of Health, Education, and Welfare to study the relationship of viruses to human cancer. The new federal grant may be the end of his work with polio which began in 1931. Dr. Sabin's live-virus polio vaccine is being administered now to about 77 million Russians and others after tests on 12 million in Russia last summer.

The causal role of viruses in cancer is being pursued by some of our best brains, and your editor will not be surprised if this research bears fruit. There is evidence that certain cancers in lower animals are caused by viruses. Dr. Sabin is of the opinion that humans should follow the same biologic law, and therein lies the need for further research in this field.

Teenage smokers

The Institute of Student Opinion found that two-thirds of America's teenagers believe that a relationship exists between lung cancer and smoking. More than 45 per cent think that both light and heavy smokers run a greater risk of getting lung cancer than nonsmokers. The poll covered grades 7 to 12 in 200 schools throughout these United States.

This demonstrates that the children read newspapers and are sufficiently interested to recall what they read. On the other hand, the fear of lung cancer has not discouraged them from smoking. The Institute reports that 5 per cent of all teenage boys are smoking at 12 years of age, 15 per cent at 14, and more than 25 per cent at 16. About 3 per cent of the girls are smoking at 13, 10 per cent at 15, and 13 per cent at 17.

Other studies have shown that the boy who leaves school to work is more likely to become a regular smoker. This may account for the statistics showing that non-smokers are better students and go further than the smoker.

More, but still not enough

The number of doctors entering training programs to become psychiatrists jumped 30 per cent, from 2,074 to 2,723 between 1956 and 1958, according to a joint report of the American Psychiatric Association and the National Association for Mental Health. Even so, they will make a very small dent in meeting the reported 13,000 shortage of psychiatrists; the increase is only a little more than 350 psychiatrists per year. Since 1956, according to the report, physicians with foreign degrees in psychiatric residencies increased 54 per cent — from 693 to 1,071, while those trained in the United States went up only 23 per cent — from 1,381 to 1,652. Ten states have no psychiatric residents in training and 22 states have none in their state hospital training programs.

Figures are tricky

At about the same time, the National Institute of Mental Health reported that for the fourth consecutive year the number of resident patients in public mental hospitals in the United States dropped in 1959—0.4 per cent less patients than in 1958. However, total admissions increased 6.5 per cent. The figures show a continued increase in the number of patients discharged from the hospitals—7.2 per cent over 1958 discharges.

"So many factors are involved in these figures that it is unsafe to draw specific conclusions from them," Dr. Robert H. Felix, director, points out, "but they undoubtedly reflect a prevailing improvement in the care and treatment of the mentally ill in and out of mental hospitals . . . There is reason for encouragement, but these same statistics show that there are still over half a million patients in our public mental hospitals. The cost of their care is in excess of $800 million per year."

Hi-fi hearing aid

Zenith Radio Corporation has announced the world's first high-fidelity hearing aid, which it says offers a 98 per cent greater range of reproduced and amplified sounds than possible through transistor hearing aids. It is reported to eliminate distortion of peaks of sounds, and nearly all background noise and permits focusing on phone conversations. Its acoustic gain is 75 decibels. The whole thing weighs "two ounces, complete with mercury battery, a five transistor circuit incorporating an interstage transformer, with push-pull output and special three terminal earphone." No woofer.

Proof that headaches are increasing

A 50 per cent increase over 1959 record production of Bayer Aspirin was planned for mid-February by the Sterling Drug Company to build a stockpile to meet expected emergency needs. Their plant in Trenton, N.J., is operating on a double-shift, overtime basis. The company is anticipating a lot of headaches among unfortunate victims of Asian influenza, which the U. S. Public Health Service announced in January "is well seeded in the country" and can be "expected to appear in many localized concentrations."

Fathers are younger

Young fathers in our country are increasing rapidly in number, the Metropolitan Life Insurance Company reports. Children born in families where the husband is under 20 years of age rose from 40,000 to 106,000—165 per cent—between 1940 and 1957. The upsurge in births reflects, in part, the earlier age at which marriage now occurs, as well as the considerably increased number of young married couples.

What do you suppose the percentage rise will be when that bumper crop of post-war babies join the young-marrieds?

The good old days

Comes a time when we all like to grow reminiscent—or listen to some one who has—as did Stephen Rothman, professor of dermatology at Billings Hospital in Chicago. The Medical Alumni Bulletin of the University of Chicago Medical School has printed Rothman's address at a reunion banquet last summer. No matter what your age, we think you will enjoy this tidbit:

"Economically and socially, Billings Hospital was a paradise. Lunch in the cafeteria cost 27 cents, and, believe it or not, it was good. When the price was raised to 29 cents, there was general protest, and some of the staff members went on a hunger strike. Those who had a car parked it in the bushes behind the building. Nobody, not even the social scientists, could have predicted the emergence of a privileged elite class of radioisotopicists with a separate, elegant, well-cemented parking lot in front of the new Argonne Hospital contrasting with the non-privileged, not-radioactive plebeians who, after the merciless removal of the bushes, still park behind the building on a terrain which competes favorably with the best roller-coasters in any amusement park."

Folklore and tradition

Pega Palo is a vine that natives in the Dominican Republic have used since pre-Columbian times for rejuvenation of elderly men. Personal interviews with men between 70 and 80 years old established the deep conviction and sincerity of the native users. Many perform hard physical work in the fields without undue fatigue. It is said also to increase the sexual capacity of elderly men. Government physicians suspect that it contains an androgen-like steroid; a tincture has been prepared by the Laboratorio Quimico Dominicano.

Two teaspoons (8 cc.) were administered to a group of 50 men who complained of loss of sexual desire and inadequate erections.[1] Libido was increased in 41 cases, and in 16 cases sexual desire was restored to normal during the period of medication. It will be interesting to know what the results will be in a well controlled study.

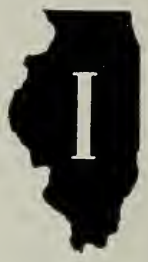
Meanwhile Reed & Carnrick have introduced Analeptone-Anabolic as a product to counter the effects of old age. It was "designed to relieve memory failures, aches and pains, broken bones, and depressions which threaten 15 million Americans past age 65."

Each tablet contains 50 mg. pentylenetetrazol, 0.83 mg. methyltestosterone, 0.0015 mg. ethinyl estradiol, and 450 mg. of strontium salicylate. The pentylenetetrazol is a cerebral stimulant, and the company claims that it improves brain cell oxygenation and nutrition.

In our mind, we'll need more information on this product to substantiate the claims for this product.

Sobá, J. G. et al.: Androgenic Action of Pega Palo, J. Nat. M. A. 52:25-28, 1960.

NEWS of the STATE



COUNTY NEWS

Adams

Public Relations. The Adams County Medical Society has secured as speaker for its annual public relations meeting on March 29 at 8 p.m. E. H. Mellon, Ph.D., superintendent of public schools, Champaign. Dr. Mellon will speak in the Senior High School auditorium, Quincy, on "Soviet Education—A Challenge to Us." The speaker, well-known in western Illinois, is one of 32 school administrators who recently made a month's educational tour of Russia. This public meeting is being sponsored jointly by the society and the Swanberg Medical Foundation.

Scholarship. The Perry W. Jennings Pre-Medical Scholarship to Culver-Stockton College, recently established by family and friends of the late physician, who practiced in Canton for over 50 years, will be presented each year to a student planning to enter the field of medicine.

Champaign

Meeting. "Aviation Medicine in the Aerospace Age" was the subject of an address by Maj. Gen. O. K. Niess, USAF, MC, Surgeon General of the U. S. Air Force, at the regular March meeting of the Champaign County Medical Society. The program also included a film entitled "Vertical Frontier."

Cook

Society Meetings. The Annual William A. Pusey Lecture of the Chicago Dermatological Society will be given by Dr. Herman Pinkus, Monroe, Mich., on "Four-dimensional Histopathology" March 16, 7 p.m., at the Illini Union. Dinner at 6 p.m. will precede the lecture. All physicians are welcome. Newly elected officers of the society are Drs. I. Myron Felsher, president; Allan L. Lorincz, vice-president; Frederick J. Szymanski, secretary-treasurer.

The Society of Medical History of Chicago on February 17 heard Dr. Morris Fishbein, editor of Excerpta Medica, speak on "Evolution of Quackery" and Dr. Frederick Stenn, assistant professor of medicine at Northwestern University Medical School, on "The Historic Importance of the McCormick Institute for Infectious Diseases."

At a joint meeting of the Chicago and Milwaukee Pediatric societies February 16 Dr. Ralph V. Platou, department of pediatrics, Tulane University School of Medicine, spoke on "Poisons—Some Pharmacologic Experiments of Nature."

"Chemotherapy of Cancer" was the subject of a panel discussion at the February 5 meeting of the Chicago Surgical Society. Speakers were Drs. Anthony Curreri, Wisconsin Medical School; Warren Cole, University of Illinois College of Medicine; and Frederick Preston, Wesley Memorial and Veterans Administration Research hospitals. Dr. John P. North, Veterans Administration Hospital, Dallas, Texas, served as moderator.

At the March meeting of the Chicago Urologi-

cal Society Dr. James A. Calams presented his candidate's thesis, "Chimney-Sweep Disease" and Dr. Charles B. Huggins, a paper on "Steroids, Growth and Cancer." A clinical meeting was held at the Albert Billings Hospital in the afternoon, when the urologic staff presented a panel "On Stones—in Patients and Animals" as part of the program.

The Chicago Gynecological Society at its February 19 meeting heard Dr. Clyde L. Randall, Buffalo, speak on "Uterine and Ovarian Malignancies Complicating Pregnancy," and Drs. William P. Wendt and David LaFond, both of Milwaukee, on "Von Willerbrand's Disease in Obstetrics and Gynecology."

At the February meeting of the Chicago Neurological Society Dr. Paul C. Bucy and J. E. Keplinger (by invitation) spoke on "Hemiballismus," and Dr. Carl F. List, Grand Rapids, Mich., spoke by invitation on "Maintenance of Function in Lesions of the Central Nervous System."

Appointment. Dr. Edward J. Beattie, Jr., chairman of the department of surgery at Presbyterian-St. Luke's Hospital, has been named vice-chairman of the medical and nursing services of the Chicago Chapter of the American Red Cross. He will be in charge of recruiting doctor-nurse teams for disaster operations in the area.

Hospital Staff Appointments. The Department of Pathology at Evanston Hospital was recently reorganized and includes the following staff members: Dr. C. Bruce Taylor, director, and Dr. Richard E. Trueheart, surgical pathologist, both formerly at Presbyterian-St. Luke's Hospital, Chicago; Dr. Ruth B. Balkin, clinical pathologist, and Dr. Harry B. Harding, clinical microbiologist, formerly on the full-time staff of Northwestern University Medical School.

Dr. Vincent C. Freda is the newly elected president of the Grant Hospital medical staff. Other new officers include Dr. Karl Gustin, vice-president, Dr. Samuel B. Nelson, treasurer, and Dr. Jerome B. Reich, secretary.

Dr. Edward M. Dorr has been elected chief of the medical staff of Chicago Wesley Memorial Hospital. Elected to serve with him are Dr. Conrad Smith, vice chief, and Dr. Clinton L. Compere, secretary-treasurer.

DeKalb

Meeting. Dr. Robert W. Ollayos, Elgin, spoke on "Some Common Problems of Pediatric Office Practice," at the February meeting of the DeKalb County Medical Society.

LaSalle

Meeting. "Practical Aspects of Hand Surgery" was the subject of an address by Dr. Frank M. Howard, clinical instructor in orthopedic surgery, University of Illinois College of Medicine, to members of the LaSalle County Medical Society February 11.

Lake

Meeting. Mr. John W. Neal, general counsel for the Illinois State Medical Society, spoke on "The Forand Bill" at the meeting of the Lake County Medical Society early in February.

Invitation. Members of the county medical society were invited by the Abbott Laboratories Sigma Xi Club to hear Dr. Arthur J. McBay, department of legal medicine, Harvard Medical School, speak March 2 on "Crime Detection and Toxicology."

Rock Island

Meeting. Dr. Thomas Baffes of Children's Memorial Hospital in Chicago spoke on "Current Concepts of Cardiac Surgery" at the February 9 meeting of the Rock Island County Medical Society.

Saline

Election. The Saline County Medical Society has elected the following officers: Dr. N. A. Thompson, of Eldorado, president; Dr. Grover Sloan, Carrier Mills, president-elect; Dr. Robert Ferrell, Eldorado, secretary-treasurer.

Blood Banks. Through the county medical society, a roster of doctors for the Blood Bank in Harrisburg is being kept by Dr. Burtis E. Montgomery, and in Eldorado, by Dr. Robert Ferrell.

Sangamon

Meeting. At the February meeting of the Sangamon County Medical Society Mr. H. J. Vasconcelles, district manager, Social Security Administration, discussed "The Social Security Program."

Vermilion

Meeting. At the February 2 meeting of the Vermilion County Medical Society Dr. Coy C.

Mason, clinical associate professor of pathology at the University of Illinois College of Medicine, spoke on "Discriminative Hemotherapy."

Winnebago

Personal. Dr. Roland I. Pritkin, Rockford, gave one of the principal addresses at the Golden Jubilee of the founding of the Henry Holland Eye Hospital at Shikarpur, Sind, West Pakistan. Dr. Pritkin is president of the Henry Holland Hospitals Alumni Association and Henry Holland Mission Hospitals Fund, both made up of American eye surgeons who have been going to Shikarpur to do eye surgery since 1911. Dr. Kenneth Somers, Washington, D. C., is accompanying Dr. Pritkin this year. They are making a study of zonulysis in cataract surgery.

GENERAL

Re-elected. Dr. Clinton L. Compere, Chicago, has been re-elected secretary of the American Academy of Orthopaedic Surgeons.

Leads Discussion. Dr. George F. Hibbert, Morton Grove, led a round table discussion on "Management of Face and Brow Presentations" at the annual congress of the Illinois Committee on Maternal and Infant Health held in Peoria early in February.

Appointments. Dr. Harry F. Dowling, Chicago, has been named to the National Advisory Allergy and Infectious Diseases Council.

Dr. Horace E. Turner, Chicago, has been selected to serve as temporary secretary-general of the International College of Surgeons at headquarters in Chicago.

Fifty Year Club. Dr. J. H. McCurry, Cash, Ark., has the approval of the American Medical Association to organize a Fifty Year Club within the AMA. He is anxious to hear from physicians who have been in practice fifty years or more and desire to join this club. A prospective member should give name and complete address. The first meeting will be held in Washington, D. C., at the Clinical meeting Nov. 29 to Dec. 2.

McKinley Staff Organized. In the first formal organization of the medical staff at McKinley Hospital at the University of Illinois, Urbana, Dr. Charles T. Moss was elected chairman; Dr. Robert M. Hoyne, vice-chairman; and Dr. Robert W. Whitener, secretary, all of Champaign-Urbana. Dr. Orville S. Walters is director of University Health Services.

The move is a part of a long-range program to improve the quality of medical care at the hospital and follows several months of planning by an advisory committee of local, university, and state medical society physicians. By-laws adopted by the staff define qualifications for membership and prescribe regular monthly meetings. Rules and regulations adopted deal with hospital procedure, medical records, and standards of medical practice.

Seventy-eight Champaign-Urbana physicians were appointed to the staff—51 to active status, 7 to courtesy memberships, and 20 to consulting memberships.

"Your Health Comes First" over Radio Chicago WJJD:

March 23 at 7:15 p.m.—William A. Larmon, assistant professor of orthopedic surgery at Northwestern University Medical School, will discuss "Bursitis of the Shoulder."

This is a public service program sponsored by the Illinois State Medical Society in cooperation with Radio Chicago WJJD.

Speakers' Bureau Activities:

Date:	February 18, 1960
Speaker:	Roger Allen Harvey, professor and head of the Department of Radiology, University of Illinois College of Medicine
Topic:	Supervoltage Therapy
	Knox County Medical Society in Galesburg
Date:	February 23, 1960
Speaker:	Sophie J. Presley, assistant professor of medicine, University of Illinois College of Medicine
Topic:	"Medical Careers"
	Josephinum Catholic High School
Date:	March 17, 1960
Speaker:	Harold H. Nelson, clinical associate, Department of Neurology and Psychiatry, Stritch School of Medicine of Loyola University
Topic:	Behavior Problems in the Aged
	Logan County Medical Society in Lincoln
Date:	March 17, 1960
Speaker:	Justin C. McNutt, member of ortho-

pedic staff, St. Joseph's Hospital in Bloomington

Topic: Orthopedics for General Practitioners Whiteside-Lee County Medical Societies in Sterling

Date: April 15, 1960

Speaker: Charles H. Lawrence, clinical assistant professor of medicine, University of Illinois College of Medicine

Topic: Colitis, Management and Treatment Stock Yards Branch of the Chicago Medical Society.

DEATHS

Galileo Albano*, Chicago, who graduated at Universita di Napoli Facolta di Medicina e Chirurgia, Italy, in 1907, died January 29, aged 77. He was a member of the staff of the Norwegian American Hospital.

Albert William Bradford, Lacon, who graduated at the College of Physicians and Surgeons of Chicago in 1895, died October 20, aged 87. He had served on the Board of Health, and at one time was president of the First National Bank of Lacon.

Louis Sylvester Brown*, Hillsboro, who graduated at Washington University School of Medicine, St. Louis, in 1902, died October 27, aged 84. He was a member of the staff of the Hillsboro Hospital.

Bernard L. Cohen*, Chicago, who graduated at the University of Illinois College of Medicine in 1932, died February 4, aged 49. He was a staff member of the Chicago Police Department Medical Bureau, and was affiliated with the South Shore and Jackson Park Hospitals.

Arthur R. Elliott, retired, Winter Park, Fla., formerly of Chicago, who graduated at Queen's University Faculty of Medicine, Kingston, Ontario, in 1889, died February 6, aged 90. For many years, he was a member of the staff of the old St. Luke's Hospital.

Perry B. Goodwin*, Peoria, who graduated at College of Physicians and Surgeons of Baltimore in 1904, died January 1, aged 81. He was a member of the Radiological Society of North America, Inc., and the American College of Radiology.

Robert Henner*, Chicago, who graduated at the University of Illinois College of Medicine in 1934, died January 21, aged 50. He was clinical associate professor of otolaryngology at the University of Illinois, head of the ear service at the Illinois Eye and Ear Infirmary, and founder and director of the Speech and Hearing Rehabilitation Center at Michael Reese Hospital.

Sophia A, Joffe*, West Chicago, who graduated at the Chicago Medical School in 1949, died February 7, aged 54. She was a staff member of the DuPage County Psychiatric Department, formerly on the staff of the Elgin State Hospital, and former supervisor of nurses in the pediatrics department of Mount Sinai Hospital.

Sidney Klein, retired, Chicago, who graduated at Rush Medical College in 1905, died January 4, aged 79. His will disclosed that he had left the bulk of his estate valued at two and one-half million dollars to Michael Reese Hospital with which he had been associated for many years.

George J. Mautz*, Springfield, who graduated at the University of Illinois College of Medicine in 1907, died January 23, aged 79.

Walter C. McKee*, retired, Chicago, who graduated at the University of Illinois College of Medicine in 1910, died February 3, aged 73. He had been a member of the staff of Children's Memorial Hospital since 1927, and also had been on the staffs of Augustana, Ravenswood and Henrotin Hospitals. He was a past president of the Medical Alumni Association of the University of Illinois.

Emery E. Royce, Sparland, who graduated at the Hahnemann Medical College and Hospital in 1898, died October 27, aged 87. He had served on the staffs of the Proctor and St. Francis Hospitals in Peoria, and was director of the Henry (Ill.) State Bank, of which he was formerly president.

John P. Sprague, retired, formerly of Evanston and Minocqua, who graduated at Northwestern University Medical School in 1903, died in Orlando, Fla., January 28, aged 86. He was founder of Camp Minocqua for Boys in Wisconsin, and helped found the National Camp Directors Association, becoming its first president in 1928.

Max Thorek*, Chicago, who graduated at Rush Medical College in 1904, died in his home January 25, aged 79. He was founder and permanent secretary of the International College of

*Indicates members of the Illinois State Medical Society.

Surgeons, and founder and chief surgeon of the American Hospital; professor of elinieal surgery at Cook County Graduate School of Medieine, an attending surgeon at Cook County Hospital, and consulting surgeon at the Munieipal Tuberculosis Sanitarium. He was editor of the Journal of the International College of Surgeons, author of many books, and had reeeived more than 2,000 prizes as a photographer.

Edward L. Turner*, Chieago, who graduated at the University of Pennsylvania Sehool of Medicine in 1928, died unexpeetedly on February 4, aged 59. He was director of the American Medical Association's division of seientifie activities. He had been seeretary of the AMA Council on Medical Education and Hospitals from 1953 until last year when the new division was formed. Before joining the AMA Couneil, he helped organize and was dean of the School of Medieine at the University of Washington in Seattle.

Arthur D. West*, Moline, who graduated at the University of Vermont College of Medicine in 1898, died Deeember 7, aged 86.

*Indicates member of the Illinois State Medical Society

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Wives and taxes

The United States Tax Court has handed down two deeisions of interest to physieians.

The first ruling holds that there is no reason why a woman who makes herself extremely useful in her husband's medical practiee should not be permitted to be his professional partner, for tax purposes, even though she is not an M.D.

After a Seattle radiologist terminated a partnership with professional eolleagues, he made his wife a business partner. The wife billed patients, purehased supplies, and eheeked elinieal reports. When the physieian died, the Internal Revenue Service held the partnership "a sham and invalid" and deelared a $24,618 ineome tax defieiency. The decision was appealed and reversed by the tax court.

However, it is well to remember that a tax ease is deeided on its own basis, depending upon the partieular faets. Soeiety members may want to eonsult their attorney regarding the possibility of ereating a husband-wife partnership for tax avoidance purposes. *Tax Court OK's Wife as Partner. Penn. Med. J. Jan. 1960.*

Illinois State Medical Society

Special Meeting Of The House Of Delegates

DECEMBER 12-13, 1959

FIRST SESSION

The first session was called to order at 7:40 p.m., at the LaSalle Hotel, Chicago, by the president, Dr. Joseph T. O'Neill, Ottawa.

PRESIDENT: The first order of business will be the report of the Credentials Committee, Dr. C. Elliott Bell, Macon County, chairman.

DR. C. E. BELL: The committee has certified 90 delegates representing more than 20 counties. We move that number constitute a quorum and the voting strength for this meeting. (Motion seconded by Dr. E. Lukaszewski, Cook County, and carried).

PRESIDENT: The next order of business is the roll call by the secretary. The chair will be glad to entertain a motion that the attendance slips constitute the roll call.

DR. E. LUKASZEWSKI, Cook County: I so move. (Motion seconded by many and carried).

PRESIDENT: It is the understanding of the chair, according to the constitution, that we may discuss proposed changes in the by-laws at this meeting, but no change can be put into effect until the annual meeting in May. Is that thoroughly understood? If there are any questions the chair will be glad to hear from you.

Our Committee on Constitution and By-laws, a standing committee of the Council, will sit in to offer assistance. The Committee on Medical Service and Public Relations will discuss any problems pertaining to the questionnaire that may arise as to our care of the aged and the insurance that would be developed by Blue Shield and Blue Cross. This committee will sit in in the morning but not as a reference committee. If you have suggestions, the committee will be glad to hear them at its meeting at 8 o'clock in the Press Gallery, 18th Floor.

While the reference committees are scheduled to meet tomorrow morning, if we get through at any reasonable hour, they may meet this evening. We will try to have Sunday's session over by 12:30 or 12:45 if possible. However, everyone will be given fair time for whatever he wishes to discuss.

The business of this meeting, as stated in the official call mailed to all members of the House, is (a) Consideration of the Ad Hoc Committee's report on the management survey made by Rogers, Slade and Hill, except those items which are the direct responsibility of the Council under the constitution and by-laws of the state society;
(b) Consideration of such other business as may be presented by the Council.

A word concerning the history of the Rogers, Slade and Hill report may be helpful. This New York firm was selected to make a survey of our Illinois State Medical Society because of its comprehensive work for the medical societies of Pennsylvania, New York, Maryland, and North Carolina. When the report was received from Rogers, Slade and Hill, the chairman of the Council, Dr. Montgomery, appointed a committee to study it and make recommendations to the Council. This committee reviewed all the recommendations made by Mr. Edlund of Rogers, Slade and Hill and brought them before the Council. I will ask the chairman of the Council to read these recommendations and to dispose of them to the various committees which have already been appointed. As they are read I will try to assign them to the proper committee.

DR. B. E. MONTGOMERY: I will read our recommendations and suggestions, and the president will refer them to the reference committee. Certain items directly referable to the Council will not be referred.

> Recommendation I, Page 6: Look forward to employing a high-grade well-paid Administrator as the Society's executive leader. Amend Constitution and By-laws to make this possible, and to remove existing limitations on the search.

PRESIDENT: This portion of the report will be

referred to the Reference Committee on Constitution and By-laws. If there are any questions, the chair will be glad to entertain a motion.

Recommendation II, Page 6: Abolish ultimately the elective office of Secretary-Treasurer. If at the start this seems too revolutionary, take it in steps instead of all at one time.

Gentlemen, you understand I am reading directly from the Rogers, Slade and Hill report — not from the report of the Ad Hoc Committee. You have all had the report of the Council committee, and that is for you to study.

PRESIDENT: This will be referred to the Reference Committee on Constitution and By-Laws. Is there any discussion? Proceed Dr. Montgomery.

Recommendation III, Page 6: Authorize an Ad Hoc Committee to prepare a "man specification" for the position of Administrator.

This is purely a Council matter that has already been taken care of. A committee has been appointed and is studying "man specifications" for the job.

Recommendation IV, Page 7: When the time comes — and many respondents believe the time is now — authorize the Ad Hoc Committee to make the search for the Administrator; to use such assistance as it deems best; to arrange the contract of employment; and to introduce the new Executive adequately both to his duties and to the people with whom he is to work.

This, of course, is under the Ad Hoc Committee for this is purely a Council matter. This committee has hired a firm to go into the matter of hiring the right individual for the job and will make recommendations to the Council when it finds a suitable man.

Suggestion I, Page 10: Add to Article II of the Constitution, entitled "Purposes of the Society," a declaration that an objective of the State Society is to serve and strengthen component County Societies.

This suggestion deals with changes in the constitution and by-laws relative to the objectives of the society.

PRESIDENT: This will be referred to the Reference Committee on Constitution and By-Laws. Is there any discussion?

DR. C. PORTES, Cook County: You have on the agenda a committee to consider the Rogers, Slade and Hill report and the report of the Ad Hoc Committee. I notice you also refer some part of it back to the Constitution and By-laws Committee. Will there be two committees to consider the same thing?

PRESIDENT: That is right. They will have some things to consider jointly.

Suggestion II, Page 10: Add to the same Article II that an objective of the Society is to improve medical care for the people of Illinois with the least financial burden on the individual.

PRESIDENT: That will be referred to the Reference Committee on Constitution and By-laws.

Suggestion III, Page 18: Let each County Society consider carefully whether greater rotation of its Delegate or Delegates is desirable, and act accordingly.

It was the feeling of both the Ad Hoc Committee and the Council that this was purely a local problem that need not be referred to any committee for discussion.

PRESIDENT: I see your point, Dr. Portes. The chairman is not reading some things in my report which the Council thought should be referred to the Edlund Committee. I will let him finish his reading.

Suggestion IV, Page 18: Publish Handbook information to all members well in advance of the Annual Meeting.

PRESIDENT: That will be referred to the Reference Committee on the Edlund Report, John Wolff, chairman. "Furnish Handbook Information to All Members Well in Advance of the Annual Meeting" (page 17) we think needs some discussion. It will be referred to the Reference Committee on the Edlund Report. The matter of dues on the same page and the first paragraph, page 15, together with last paragraph entitled, "Prescription" on page 15, will be referred to the Committee on the Edlund Report. Proceed, Dr. Montgomery.

Suggestion V, Page 19: Hold County or District caucuses for discussion in advance of the Annual Meeting.

PRESIDENT: This is referred to the Reference Committee on the Edlund Report. Any questions? Proceed, Sir.

Suggestion VI, Page 19: Consider interim meetings of the House of Delegates in centers other than Chicago.

This is apparently a matter that will have to be decided by the Council.

PRESIDENT: Is there any objection to the decision of the Council regarding this recommendation? You may proceed, Sir.

Suggestion VII, Page 23: Do not by By-law limit the tenure of Councilors. Each District should take care of this for itself. For any District which may desire an alternative method of choosing its Councilor, one device is suggested above. Continued study may well be given to developing other "better ways."

This, as you remember, was taken care of by vote of the House of Delegates in May of this year, therefore need not be referred.

[Ed. Note: The following Suggestions and Recommendations were read and referred to the Council.]

Suggestion VIII, Page 23: Seek to give at least equal time in Council meetings to matters other than legislative. If this requires additional Medical Service machinery, create it.

Suggestion IX, Page 23: Spread Committee appointment much more widely among members of the Society than is the practice at present. Cut down Committee assignments of Councilors; in general, not more than one Committee for any Councilor.

Suggestion X, Page 24: Provide the Council with more advance agenda and supporting data. Aim at decisions in Council meetings with fewer postponements and referrals to Committees, and much more on discussion and decision by the entire Council based on carefully compiled information supplied in advance to the Council members.

Suggestion XI, Page 24: Signing of vouchers by the Finance Committee to be done at other times than during the Council meetings.

Suggestion XII, Page 24: Consider whether more frequent Council meetings are needed, or meetings of longer duration such as all day or an evening and a morning.

Recommendation V, Page 26: Look forward to employing high-grade Field Administrators to assist the Executive Administrator, the Councilors, and the Public and Professional Relations Committee and staff in contacts with County Societies, County officers, members, and various groupings of members such as in hospital staffs and city branch Societies.

Recommendation VI, Page 29: Look forward to continuous development of public and professional relations, including projects in the service of the public at State and local levels, and including development of many and various programs such as those outlined in the pamphlet "The Public Relations of County Medical Societies" first published by ISMS in 1953.

Suggestion XIII, Page 29: Consider dividing the Constitutional Committee on Medical Services and Public Relations into two committees, one on Medical Services, the other on Public and Professional Relations. Take steps, nevertheless, through the Council or in some other manner such as a joint chairmanship, to see that the activities of the two Committees are coordinated.

PRESIDENT: This will be referred to the Reference Committee on Constitution and By-laws. Proceed, Dr. Montgomery.

Suggestion XIV, Page 31: Consider whether physician contacts with officials and legislators can be further organized and developed.

That we felt also was a matter for the Council or one of the Council committees.

Suggestion XV, Page 31: Consider what future relationships should be developed with the Associate Counsel at Springfield, since he must determine whether to engage more extensively in private practice as a lawyer or to reserve and develop time for the service of the State Society.

That again, the Council thought, is a matter for the Council.

Recommendation VII, Page 34: Look forward to employing a high-grade, well-paid Editor on full or substantial time.

This by virtue of the constitution and by-laws is referred to the Council.

Recommendation VIII, Page 34: Authorize an Ad Hoc Committee to prepare a "man specification" for the position of Editor.

This has already been done.

PRESIDENT: This is again a Council matter, according to our interpretation. Proceed, Dr. Montgomery.

Recommendation IX, Page 35: When the

time comes, authorize the Ad Hoc Committee to make the search for the Editor; to use such assistance as it deems best; and to arrange with the candidate his contract of employment.

The committee has it under consideration. It is, however, thought to be a matter for the Council.

PRESIDENT: Is the House in agreement with that decision of the Council? Proceed, Montgomery.

Suggestion XVI, Page 37: Continue for the present the Society's program of Postgraduate Conferences for those who ask them and who attend in reasonable numbers.

PRESIDENT: This suggestion will be referred to the Reference Committee on the Edlund Report. Proceed, Dr. Montgomery.

Suggestion XVII, Page 37: The whole subject of Postgraduate Education in Illinois as between the Medical Schools, the hospitals, the Academy of General Practice, and other instrumentalities, appears to need further continuous study, which we suggest be given it.

PRESIDENT: This portion of the report is referred to the Reference Committee on the Edlund Report. You may proceed.

Suggestion XVIII, Page 38: Arrange for greater continuity from year to year in the development of scientific programs. This may well include study of the most successful programming of other state societies and organizations. An over-all continuing committee seems desirable.

PRESIDENT: This matter has been before the Council many times. Only today further action to implement a study of this character was taken by the Council. We are going to refer this to the Edlund report committee and will welcome any suggestions. Proceed, Dr. Montgomery.

Suggestion XIX, Page 38: Continue the effort begun this year to avoid conflict in time between the House of Delegates and Reference Committees, and scientific and general meetings. The over-all continuing Committee proposed in Suggestion XVIII may well study how other State Societies and organizations handle this problem.

This we felt was a matter for the Council.

Suggestion XX, Page 38: For commercial exhibitors there should be a temporary Exhibit Director to whom they can turn with their problems. During the Annual Meeting, this individual should not be burdened with other responsibilities, but should be free to help exhibitors achieve maximum satisfaction from their exhibits.

PRESIDENT: The Council has already taken steps to put this proposal into effect at the meeting this year. There will be in the exhibit hall at all times an exhibit director to whom the exhibitors can go with any of their grievances. We think that will be good public relations. If there is any discussion we will hear it. Proceed, Dr. Montgomery.

Suggestion XXI, Page 38: Attention should be given to the formal "Summary of Recommendations" published by the Medical Exhibitors Association, Inc. For example, one plan adopted this year by the Illinois Society runs counter to the following from the Summary: "The results of a survey conducted by this Association indicate that the majority of our members are opposed to the practice of offering prizes to registrants at meetings in order to assure attendance at the booths of the exhibitors."

This we felt was a matter for the Council.

PRESIDENT: It there any discussion? The Council felt that this might increase the attendance. The committee which was appointed by the chairman of the Council to study the different aspects of the annual meeting recommended that this be done this year as it was last year. Is there any deviation from that opinion? Proceed, Dr. Montgomery.

Suggestion XXII, Page 38: Audited statements by the Society's auditing firm should show the classification and amounts of expenditures and receipts connected with the Annual Meeting, the exhibits, and each feature or part of the meeting.

This is also a matter for the Council.

Suggestions XXIII and XXIV, Page 39: Headquarters. No respondent, save one, believes that Monmouth is a good headquarters for the Society. Debate as between Chicago and Springfield brings out many advantages for each.

PRESIDENT: An Ad Hoc Committee appointed by the Council to study the location of the headquarters office is sitting as a reference committee. They will be glad to have you specify your views

at their meeting tomorrow morning. Are you ready to make some type of report tomorrow morning, Dr. Reavley?

Dr. L. S. Reavley: Yes.

President: The committee is headed by Drs. L. S. Reavley, C. Paul White, F. Garm Norbury, R. C. Oldfield, and Arkell M. Vaughn, all past-presidents. Will you proceed, Dr. Montgomery.

> Suggestion XXIII, Page 40: Appoint an Ad Hoc Committee to plan during the coming year for Society headquarters with the request that it submit a report and recommendations as early as practicable and in any event by the Annual Meeting of 1960.

President: This Suggestion XXIII is being referred to the Reference Committee on Location of Office. Proceed, Dr. Montgomery.

> Suggestion XXIV, Page 40: Take steps at an early date to purchase for the Chicago office, modern addressing and folding equipment, graphotype, electric stapler, and duplicator that can handle cards automatically.

This being a matter of expenditure of funds, we thought it should be referred to the Council.

President: Is there any deviation concerning this decision of the Council? Proceed, Dr. Montgomery.

> Suggestion XXV, Page 42: Look forward to increasing by $10 a member the amount of dues to be made available each year to the general work of the Society. Take whatever time is necessary to prepare the way: let education and a tentative budget win reasonable acceptance before the issue is forced.

All matters on finance are referred to the Council automatically. This matter in Suggestion XXV was discussed and implemented at the annual meeting last May, when information indicated that further increase of dues might be necessary when the whole organization program was in effect.

President: This will be referred to the Reference Committee on the Edlund Report. Proceed, Dr. Montgomery.

> Suggestion XXVI, Page 42: Adopt the actual budget and plan when you know what dues income can be counted on.

[Ed. Note: The following Suggestions regarding finances were referred to the Council.]

> Suggestion XXVII, Page 43: Quarterly audits instead of annual only.
>
> Suggestion XXVIII, Page 43: $50 per diem for the President.
>
> Suggestion XXIX, Page 43: For the Council, the quarterly audits to provide tables showing items now allocated to various accounts. For example, show all travel expense in one place, classified under the different accounts. The same for salaries and wages, rent, and other basic expenses.
>
> Suggestion XXX, Page 43: A Speaker and Vice-Speaker, with terms limited, to save burdens on the President at the Annual Meeting.

President: This matter will be referred to the Reference Committee on Constitution and By-laws who have already given it a great deal of thought. Proceed, Doctor.

> Suggestion XXXI, Page 43: A continuing Committee on Committees to keep on developing suggestions by streamlining and coordinating Committees and also, by suggestions of names, to assist in bringing new men into Committee work and in avoiding too many Committee assignments to the same persons.

This is a matter for the Council and has already been done to a certain extent by it.

> Suggestion XXXII, Page 43: A Committee on Yearly Objectives. The President-Elect to be chairman, leading the Committee in developing specific objectives for the Society for the year in which he is to be President. The President-Elect to include these objectives in an address to the House of Delegates just prior to his inauguration as President. In the year following, include in his address as President a review of the objectives and what has been achieved.

President: This Suggestion XXXII is referred to the Committee on the Edlund Report.

Dr. Montgomery: That constitutes all the recommendations and suggestions in the report.

Dr. E. V. McCarthy, Cook County: Would you please state exactly what you mean by the Edlund report and what it comprises?

President: We mean the committee to consider the Rogers, Slade and Hill report and the report of the Ad Hoc Committee.

Dr. McCarthy: Quite all right, but I am puzzled by the name Edlund.

President: The name Edlund comes from the

gentleman who was sent out by Rogers, Slade and Hill to make the survey.

Dr. H. Mantz, Madison County: I appreciate Dr. Montgomery's remarks. I would like to add to them, if I may. This report that we have here has cost our society a great deal of money. I have no objection to referring things to the Council and giving to Caesar the things that belong to Caesar. They have reserved to themselves certain things in this report to which they are entitled. In view of the alarming amount of money it cost us, I think the Council should consider reporting it to the House in this meeting, point by point. The governing body of this society is the House of Delegates and the Council should be reminded of the fact that it is responsible to the House. I would like to ask that a special reference committee be appointed to consider the Council action on the things brought up in this report. Thank you very much.

President: Does the chair take it that you make that in the form of a motion?

Dr. Mantz: No, I did not. It was a recommendation only.

President: As we went through each recommendation, the Council took some under its wing, and we asked if there was any deviation from the decision of the Council. We heard none. We have heard one now. I should like to ask Dr. Montgomery, the chairman of the Council, if he wishes to make any comment.

Dr. Montgomery: I am sure the Council would be happy to make a detailed report, as they do at every annual meeting, covering every item stated in the report as referred to the Council. Those things were done purely because they happened to be matters of Council business. It was thought that it would keep down some arguments if certain things which were functions of the Council would be given to the Council. I am sure the Council would be delighted to present a detailed report.

Dr. Mantz: Unless I have been misunderstood, that is a matter of duty. I think the House of Delegates should have opportunity to review these matters. I did not make a motion; I made the suggestion that a special reference committee be appointed to consider the Council action on the things brought up in the report.

President: I appreciate your reports.

Dr. C. Paul White, Henry County: It seemed to me, Dr. Montgomery, in reading the report, was showing us how these items had been assigned. Now, what he has finished doing is to clear whether there is any question before we accept this report, if we do. I believe that is the reason he appeared in the first place and read it. We have had a chance to question him, and we will have a chance to vote on it. When we do, the coast is clear and the green light is ahead.

President: It has been the purpose of the administration, which includes the Council and your duly elected officers, to give you information. We want you to have all the information you want to have. We realize that your time is valuable. There are some things that the constitution provides the Council take care of. These have been done. We appreciate your information.

Dr. Mladen Mijanovich, McHenry County: I want to take objection to what Dr. Mantz said, that the House of Delegates is the governing body of this society. It seems to me that most actions must be referred to the Council. I have, therefore, acquired the impression that the governing body is not the House of Delegates, but the Council. I am wondering why most of us take time to come here. There is no rule about the governing body.

Dr. Montgomery: I think if you will notice in the constitution and by-laws there is reference only to the expenditure of funds and property. The duties of the Council are simply the duties of any Board of Directors of any corporation; it has nothing to do with the formation of policies. That is all done by the House of Delegates.

Dr. Mijanovich: I would like to make a motion that the Council be authorized to come to the May meeting with their action on the various things that they have retained from the Rogers, Slade and Hill report, with report of the action they have taken. (Motion seconded by Dr. A. J. Sullivan, Cook County.)

Dr. White: I would like to ask you how can we make a motion on that when we have not accepted the report.

President: The chair will rule that the motion is in order.

From the floor: How can we vote until we know what the Council will do?

President: Does the chairman of the Council care to answer that?

Dr. Montgomery: I think if you will read your Journal you will find that the minutes of the action of the Council are published, and that is in the hands of every member of this House of Dele-

gates as well as every member of the state society. The Council has no secrets from any one. Some of these things which we referred to in the report were not matters of policy; they were things which have been done to expedite to a certain extent the action on things that are going to be necessary if we go through the reorganization of this state society so, we feel, that it will function to the betterment of every member of this society. Anyone who wants information on what the Council has done, if he reads his Journal will find it in the minutes. Several of the councilors, including myself, have instituted meetings following each Council meeting, and we have gone over all the things considered and done by the Council. I have delegates from my District who can tell you I have called this meeting after every Council meeting. We go through the whole agenda so they know what was done. I do not know what more we can do to familiarize you with what has been done.

Dr. E. A. Piszczek, Cook County: The doctor from McHenry County asked why we are meeting here. If he will read the minutes of the May meeting, he will find it states that a special meeting might be called to consider the Edlund report.

Dr. W. A. Moore, Richland County: I have the official document from the Secretary of State which gives the original incorporation and the changes which have been made. The Secretary of State may be wrong, but there is nothing in here that gives the Council all the power of authority it has taken. Maybe you do not regard all these things the Secretary of State has said, but they are in your incorporation. And if you will let me read what the authority of the Council is, it says: "The management of the state society will be by the Council . . . . ." then it says, ". . . . . nine directors are to be elected as the by-laws direct. . . . ." That is the original authority of this corporation, the Illinois State Medical Society. There are a number of things that do not appear in the Council by-laws. You say they have been changed. If they have, the Secretary of State does not know anything about it. I question the legality.

Dr. R. E. Heerens, Winnebago County: These arguments point up a statement made by Mr. Edlund. I have a great deal of respect for Dr. Montgomery and the rest of the Council, but they are stuck with things designated in the constitution and by-laws. Our society is not like a corporation; the Council does not have to report to the House of Delegates. There is nothing mandatory for the Council but to exchange information. I think this statement should be reckoned with. I think a change in the constitution should be made, that the Council should make certain reports to the House. Mr. Edlund, on page 18, says ". . . . It should dispel a feeling which some respondents voice that the Council takes too much upon itself, not sufficiently regarding itself as the servant of the House rather than the arbiter of all that is planned and done." The constitution says that the Council is not the servant of the House, and Mr. Edlund knows in Pennsylvania and Maryland the Council is. This is a matter that should be discussed. It is a problem that concerns all of us, and I think we should discuss it.

Dr. Mantz: In the first place, this House of Delegates elects the councilors to this medical society. If we have no confidence in them, we should not elect them. I think they have done a very good job. I have not found a time when there was any important matter that the Council did not report to the House of Delegates. The only reason I got on my feet was to request that the Council respectfully make a special report. I, too, resent the implication that the Council is running away with the society. We elect these men. We should have confidence in them.

President: Is there any further discussion? The secretary will read the motion. (Motion read.) The question is called for. The motion is carried, and it is so ordered.

The next item on the agenda is the introduction of resolutions. The chair recognizes Dr. Kenneth Schnepp of Springfield, representing the Sangamon County Medical Society.

Dr. Schnepp: I have the following resolution submitted by the Sangamon County Medical Society:

> *Whereas,* the location of the Illinois State Medical Society's office or offices should be in that place or those places which will enable the Society's programs, objectives and services to be developed and administered efficiently and effectively, and
>
> *Whereas,* of the society's many activities, one important phase is its legislative surveillance and program on matters pertaining to medicine, and
>
> *Whereas,* medicine's problems are constantly becoming more crucial and complex, its voluntary concept less secure and its scope of private care annually curtailed due to inroads

made by legislative enactments, state as well as national, and

Whereas, only by close liaison, effective contact, constant vigilance, development of better understandings, availability of information for and prompt action with those individuals and groups responsible for the enactment of our laws can an effective legislative program be successfully carried out, and

Whereas, 29 state medical societies, many with situations comparable to Illinois (Indiana, Michigan, Minnesota, Ohio, Pennsylvania, Texas, Wisconsin), have become aware of these facts and have deemed it to their advantage to have their Headquarters Office located at the site of their legislative assemblies, and

Whereas, the routine administrative functions of a Headquarters Office can be carried out in a downstate location as well as in a metropolitan area, and

Whereas, the Illinois State Medical Society should endeavor to develop a closer working liaison with the governmental medical departments and the para-medical health agencies located at and operating from the State's capital, and

Whereas, to closer unify the "downstate" physicians toward greater cooperation and organizational interest, there is a need to provide them with a centrally located, readily available Medical society office, and

Whereas, tangible benefits such as economy of operation, adequacy and variety of office space, availability of clerical personnel, public relations contacts and numerous other advantages would accrue from an office located in the State's legislative center, and

Whereas, many other state organizations have found it advantageous to their programs and projects, as well as economical to their treasuries, to have their headquarters office located at the site of the legislative assembly,

Therefore be it resolved, that the Illinois State Medical Society have its headquarters office, administrative office, or secretary's office, by whatever name it shall be designated, located in Springfield, and

Be it further resolved, that this office be closely integrated with and work in liaison with the state society's legislative office, and

Be it further resolved, that the state society's Chicago office be maintained in essentially the same capacity and function as it now exists, for the society's public relations, scientific, educational and assembly projects, and that Chicago be considered the location of choice for the holding of the annual meeting and all other meetings that have heretofore been traditionally held there.

PRESIDENT: The resolution introduced by Dr. Schnepp will be referred to the Committee on Location of the Headquarters Office, Dr. L. S. Reavley, chairman.

DR. J. M. MILLIGAN, Kane County: The delegates from the ten counties which make up the first district of the Illinois State Medical Society met in Rockford on Sunday, October 25, and by a unanimous vote of those present adopted the following resolution:

> That the Illinois State Medical Society reconsider its action taken on the Supplementary "H" report as presented in the questionnaire to the members of the society because of ambiguous implications.

I move that the chair give this the status of a reference committee tomorrow morning. (Motion seconded.)

PRESIDENT: This is not pertinent to the call for the meeting.

DR. E. V. MCCARTHY, Cook County: May we have the resolution re-read.

(Dr. Milligan reads the resolution.)

PRESIDENT: Is there any discussion?

DR. P. T. DOLAN, Kane County: I would like to disagree with the chair. I have talked with delegates from ten counties, and not one single one agreed that they knew what the *closure rule* means. The urgency of the matter itself has often been pointed out by officers of the society. This is not a matter that can be let go.

PRESIDENT: The chair renders his opinion according to Item No. 5 on Page 2 of the agenda.

DR. E. W. CANNADY, St. Clair County: I am speaking not merely as a delegate from my county but now as chairman of the Committee on Aging. I think it is extremely important that this be taken up. It was my understanding that the House instructed that physicians be polled as to whether they would be willing to provide low-cost medical care for those over 65. There is a lot of confusion. In my county a week ago Thursday night two had

sent in their ballots. Quite a number said they had not received them. I do not believe that. I believe they were mislaid. It is a subject they do not understand. They wanted to know what age. They were asked whether they preferred the Chicago plan or the Rockford plan. Unfortunately, too many physicians are not too well informed about the plans as they should be. This is urgent. In January the Forand Bill will come up again. Thursday night, Senator Douglas met with us. He said, "Gentlemen, the Forand Bill will not be passed in 1960. You have got a year to show us what you will do." There is a lot of confusion. Medicine is on the spot to see what it will do. It is important to have this clarified for all the doctors of Illinois.

Dr. Milligan: In the supplementary "H" report, as adopted by the American Medical Association, it did not say "payment in full." In our questionnaire some one put "payment in full" at the end of the report. There is something here that we do not understand, something that is important because if this Forand Bill goes through, we are all through. We have to do something about it. This is not the answer we would like to have; it is a way out.

Dr. M. R. Saxon, Kendall County: I must agree on one item. I think the gravity of the situation is certainly one to be considered. I notice in some of the literature passed to us as we entered was a special report on the White House Conference on Aging for distribution to each member of the Committee on Aging and members of the Council of the Illinois State Medical Society. I understand that the White House Conference on Aging will be held in January, 1961. That is about a year from this coming January. Apparently Senator Douglas in his remarks to the other medical society representatives said that we have to do something about that. They want to see what we are going to do. I do not know what was in essence his basic opinion. I am speaking not only for myself but for most men in the practice of medicine who were interrogated. We have an unquestioned obligation that we fulfill very well. People live to a ripe old age and are candidates for old age benefits because we keep them alive that long. In consideration of the A.M.A. policy and that discussed by the Committee on Aging in our last meeting in May, 1959, our county medical society by way of proposing positive action, has formulated a resolution which I would like the privilege of the House to read. If this requires a two-third vote, I would ask for it.

President: There is a motion before the House.

Dr. E. S. Hamilton, Kankakee County: May I have the privilege of the floor?

President: Granted, Dr. Hamilton.

Dr. Hamilton: This discussion concerning the questionnaire is of considerable interest to me. A change was made in the Public Relations Committee following the election of Dr. Hopkins to the Board of Trustees of the A.M.A. This job was referred to me. I agree with a good deal of the criticism leveled at the questionnaire. I had some of this questionnaire given to me when I took over the job. Consultation with the people at the A.M.A., the action taken at the session in Minneapolis, and consultation with the Blue Cross and Blue Shield, resulted in the questionnaire which was presented to you. To those of you who have read it, it was very clear. I hope you read it. I had about 25 people call me up and ask what to do. I said to read it, sign it, and sent it back. They must have done so because we got about 4,000 back. I agree with the gentleman from Kane County. We asked a few very simple questions, such as what county you were from. We asked that because we wanted to see what the reaction was in each county. Next, what is your specialty? We listed 26 and asked you to select one. Next, we asked if you agree with the policy adopted by the A.M.A. House of Delegates, *yes* or *no*. We did not ask whether you liked it; we did ask you whether you agreed with it. Then we asked, would you cooperate in a prepayment plan of payment in full, which was inserted at the request of Blue Shield, and you had to answer *yes* or *no*. That was simple enough. Now we come to No. 3. I agree I never saw a question that was so hard for people to answer: "In the county in which you perform the major portion of your practice, how would you define . . . . low income? How would you define modest resources?" Resources is what you have. If you have a Ford that is a resource; if you have two Cadillacs that is a resource. What do you consider a person of moderate resources? Next, "What do you consider low family income?" Low family income means the money you take in during the year. I do not think it is so complicated but I do not think we took time to figure it out. Question No. 4, "What fees would you agree to accept that you believe are commensurate with the income and resources of this group of persons?"

Now we have compiled these 4,000 replies. We have put them on cards and run them through the IBM machine. We could, if we saw fit during this meeting, tell you the results. We are going to be in the Press Room on the 18th Floor and you can come up.

PRESIDENT: The chair wishes further to state his position in this matter. I am reading from the constitution of the Illinois State Medical Society on Page 13, paragraph 3:

> When a special meeting is thus called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

My purpose in reading it is not to argue with you but to show you the position of the chair. If you wish, you can make a motion to over-rule. It is in tradition to move according to the position and purpose of the chair. If you wish to have this referred to a reference committee, it will take a two-thirds majority.

The parliamentarian says it will be necessary to take an appeal from the action of the chair. I would like to ask whether you wish to take an appeal.

DR. HEERENS, Winnebago County: I move that we take an appeal from the position of the chair. (Motion seconded.)

PRESIDENT: There is no collusion about this meeting; it is open and above board. The chair will carry out any action you may take.

DR. ELMER V. MCCARTHY, Cook County: You should have a vote by ballot.

PRESIDENT: All those in favor of over-ruling the position of the chair will please stand up. I will ask the secretary to take the standing vote. All those in favor of maintaining the position of the chair, please stand.

Gentlemen, you have overruled the position of the chair. It is your privilege to discuss anything you may care to. Is there any further discussion on the motion made by the doctor from Kane County? Do you understand the motion? (Dr. Milligan re-reads his motion. The vote is taken and the motion carried.)

The *ayes* seem to have it. It will be necessary for the president to make a new reference committee; as I do not want to ask the Committee on Public Relations to sit as a reference committee, I will appoint a special reference committee to hear this. They will meet in the Press Room on the 18th Floor tomorrow morning at 8 o'clock.

Are there any other resolutions?

DR. SAXON, Kendall County: Our county medical society recently adopted a resolution which, in part, pertains to summary material. We would like to have it a part of committee reference and discussion. I appreciate this will also take a two-thirds vote. I would like to have the privilege of presenting this resolution.

PRESIDENT: You may proceed, Dr. Saxon. The meeting is open, it will not require a two-thirds vote.

> *Whereas,* present and expected intrusions of increased socialism into all fields of endeavor as well as into the field of medical care are symptoms of a disease, that is, personal irresponsibility aggravated by inflation, and
>
> *Whereas,* solutions to each of these problems created in advance by those who propose further socialism only intensify inflation and further encourage personal irresponsibility, thereby creating more inequities and problems, and
>
> *Whereas,* separate rear guard actions against each individual legislative proposal of further inflationary and freedom-eroding solutions are ineffective and only arise after the proposal has gained widespread sympathy and support, and
>
> *Whereas,* the objections of those few who are to be exploited in implementing such legislative proposals appear to have only selfish interest when they object, and
>
> *Whereas,* the Illinois State Medical Society and the American Medical Association have adopted in principle a policy of combating only those proposals for socialism involved in medicine and only on individual proposals after each has gained headway and only by equally socialistic alternatives, and
>
> *Whereas,* such a policy does not join with all the other groups who oppose socialism and inflation and does not attack the basic issues, and
>
> *Whereas,* the A.M.A. membership consists of two hundred thousand and represents an essential structure in the social welfare and

the health of our nation as experts in these fields, but apparently politically impotent when standing alone on socialistic issues in medicine.

Be it resolved, that the Kendall County Medical Society opposes the policy of the A.M.A. and Illinois State Medical Society as exemplified by their opposition to, and alternative proposal to, the Forand Bill, and

Be it further resolved, that the Kendall County Medical Society respectfully encourages the delegates of the Illinois State Medical Society to the American Medical Association to voice their disapproval of this policy and instead propose a policy of direct action, propaganda, and political lobbying against all legislative proposals of socializing and inflationary tendencies in all fields in concert with other organized groups of like philosophy, and

Be it further resolved, that the delegates of the Illinois State Medical Society to the American Medical Association propose that all available channels of public communication be used in such a program and that it be financed by an increase in the annual dues of the American Medical Association.

PRESIDENT: The position of the chair in regard to this resolution is as follows: There are parts of this resolution which are pertinent to the subject which has been discussed, our questionnaire. There are also parts which are not germane to that particular subject. The position of the chair is that you have overruled the chair in that one point, that you have overruled the Chair that you might introduce this resolution from Kane County and have it presented to a reference committee and have the reference committee bring in a report. This subsequent resolution seems to contain parts which may be considered. The chair will rule that the resolution may be considered in part, if there is no objection. If there is any, the chair will be glad to hear it.

DR. SAXON: Out of due respect to our efforts and the efforts of the chair, we would like to have some information as to what parts would not be considered.

PRESIDENT: This is going a little bit too far afield, it seems to me. The position of the chair is that that part of the resolution which is germane to the Forand Bill is extremely pertinent, but the subjects set forth in the written resolution in which they memorialize the delegates to the American Medical Association to urge the A.M.A. to make a vigorous campaign against socialized medicine seems not germane to this subject. I am sure your resolution will receive good treatment before the committee.

DR. CANNADY: I am afraid that I must admit that on this resolution that was passed a little while ago I was somewhat confused, and I believe others are too. It was my impression when the motion was made to overrule the chair that the Committee on Public Relations would be given reference committee status to consider the questionnaire. Since I voted for that, I have the privilege of moving a reconsideration. I do not think we should review this whole thing. They are loading us; Douglas is in favor of the Forand Bill. He says, "You have a year to come up with your ideas." Should we reconsider this action taken at the House of Delegates meeting, we are licked. This is going to be steam-rollered through, and they will point to Illinois as the one responsible. I move reconsideration of the motion that was passed.

PRESIDENT: Pertinent to the motion, it is understood that the doctor from Kane County simply proposed that the Committee on Public Relations clarify the questionnaire, that full discussion be given, and that it be given the status of a reference committee. If I am correct in my assumption, he said nothing about rescinding the action of the House of Delegates in May. Their group in the district is a little in doubt about the questionnaire. Is not that right, Dr. Milligan?

DR. MILLIGAN: That is essentially correct. However, there are points in need of clarification that should be brought up in the reference committee and also in the House of Delegates. It is certainly true that this was passed by the A.M.A. and by the House of Delegates. I think the House of Delegates should give us a fair trial and a fair hearing to reconsider.

DR. N. POWERS, Peoria County: I would like to refer you to your constitution and by-laws. "When a special meeting is called . . . the notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called." Our meeting was called for discussion of the report of the Ad Hoc Committee and the Edlund Report. None of the discussion on the floor has been brought up. I think we

are out of order; we wish to go back to the business of the day.

President: Thank you for your information. A vote was called to overrule the president; the vote was taken and passed. I do not know whether you may reconsider anything.

Dr. Cannady: I wish to hear the resolution from Kane County.

(Resolution re-read)

Dr. C. Portes, Cook County: This resolution states that the questionnaire was ambiguous. What do they want? Do they want to reconsider the questionnaire or the action taken by the A.M.A.?

President: I think that could be brought up.

Dr. Cannady: According to that resolution, we must reconsider the entire resolution and for that reason I move reconsideration of that motion. (Seconded by Dr. C. Portes, Cook County.)

President: The chair will rule that if the proponent of that motion, Dr. Cannady, voted to introduce that motion, he may call for a reconsideration; if he did not vote, he may not call for reconsideration.

Dr. Cannady: I voted for it.

President: The chair recognizes Dr. P. T. Dolan of Kane County.

Dr. Dolan: I would like to urge upon the chair and the assembly that since the questionnaire was devised to implicate the A.M.A.'s action, it should be clear to all the members. Consequently I think Dr. Cannady fears that Illinois will be pointed to as being the bad boy.

President: Will the secretary re-read the motion? (Motion read.) This is a motion to reconsider. (The vote was 66 to 57 to reconsider.)

From the floor: There are only 90 delegates.

President: I will ask Dr. Bell, the chairman of the Credentials Committee, to give us the report.

Dr. Bell: At the time I made the report I said there was a quorum present; I did not report the full number of delegates. The committee has certified 31 officers, councilors, past presidents and A.M.A. delegates; 76 downstate members; 62 Cook County delegeates, a total of 169.

Dr. Milligan: I would like to ask what is the status on this resolution. This was settled last May without any reference to the delegates. What is the status of the resolution?

President: The chair recognizes Dr. Cannady.

Dr. Cannady: The statement was made that we as delegates had nothing to say. That is not true. This was hashed over in the reference committee for hours last spring. It was discussed in the House and it was passed, that physicians be polled as to whether they would be willing to provide medical care for those 65 and over. This is as democratic as can be. They are still going to be polled; why should we take that away from them?

President: The ruling of the chair is that the whole thing is on the floor again.

Dr. Milligan, Kane County: That should give this resolution the status of a reference committee to be considered tomorrow morning.

President: The vote is called for. (The motion was carried.) It is so ordered.

For your information so you may know to whom you are going to talk tomorrow morning, the chair has appointed the following reference committee to hear this matter in place of the Committee on Public Relations: Dr. E. W. Cannady, Chairman, Paul Dailey, George Turner, C. K. Wells and Eugene McEnery.

Dr. Cannady: I will be glad to assist in any way I can and give all the information I have on hand, but I think it would be much better to appoint some one else as chairman.

President: Are there other resolutions? We will make Paul Dailey the chairman of that reference committee.

Dr. William G. Gillies, JoDaviess County: May I have the privilege of the floor?

President: Yes, Doctor.

Dr. Gillies: At a recent meeting of the JoDaviess County considerable discussion was carried on regarding the recent order of the Public Aid Commission.

President: I will have to rule you out of order. There is nothing pertinent in that resolution. The chair was overruled but only on one point. I cannot entertain that resolution unless the House again wishes to overrule the president.

Dr. Gillies: I do not know how they can decide until they hear the resolution.

President: Is it the will of the House that we hear what the young man has to say?

(Dr. Gillies reads the resolution)

President: I am entirely in accord with your views. I am sure the members of the Advisory Committee to the Illinois Public Aid Commission will be appreciative of your effort. I will have to lower the boom on you as far as allowing action on it at this meeting. If you wish to overrule the chair, you may. (No action taken.)

You all know of the sudden death of Dr. Harold

M. Camp, Mr. Illinois Medical Society himself. I would respectfully ask the House to stand at attention for 10 seconds in his memory.

PRESIDENT: When we had news of the demise of Dr. Camp and when we attended his funeral, as many of us did, we realized that we should look for some one to take his place. The Policy Committee of the Council held a telephone meeting, the Executive Committee of the Council met, and then at the Council meeting official action approved the recommendation. We were extremely fortunate in being able to find a man who could take over the reins without disturbing the way we run our state society. You know him well. I wish to present to you Dr. George Lull, secretary pro tem.

The chair will entertain a motion for adjournment.

It was moved, seconded, and carried that the House adjourn until 11 o'clock Sunday morning.

The House adjourned at 9:45 p.m.

SECOND SESSION

The second session of the House of Delegates was called to order on Sunday, December 13, 1960, at 11 a.m. by the president, Dr. Joseph T. O'Neill.

PRESIDENT: The chair will call for the report of the Credentials Committee, Dr. C. Elliott Bell, chairman.

DR. BELL: The Credentials Committee reports that a quorum is present. The voting power will be determined later.

PRESIDENT: Thank you, Dr. Bell, for the preliminary report. We will call for the complete report as soon as you are ready.

The chair will entertain a motion that the report of the Credentials Committee constitute the roll call.

DR. E. LUKASZEWSKI, Cook County: I so move. (Motion seconded and carried.)

DR. C. PAUL WHITE, Henry County: I would like to move that this House of Delegates go on record as approving the action of the Council in appointing Dr. George Lull as temporary secretary. (Motion seconded by many and carried by a rising vote.)

PRESIDENT: The first item on the agenda is the report of reference committees. We will hear from the Committee on Location of the Headquarters Office, Dr. Lester S. Reavley, chairman.

Ad Hoc Committee on Location of Society Office

Your Ad Hoc Committee for location of the society office wishes to make the following majority report:

The committee recommends that the Sangamon County resolution be disapproved and that a substitute plan be offered.

The committee wishes to offer the following plan: That the administrative office be in Chicago and an office be established in Springfield, and that the functions of this office shall be determined by the Council.

Respectfully submitted,

(Signed)

LESTER S. REAVLEY, M.D., Chairman
F. CARM NORBURY, M.D.
ARKELL M. VAUGHN, M.D.
C. PAUL WHITE, M.D.
RALEIGH OLDFIELD, M.D.

DR. REAVLEY: I move the acceptance of this report as a whole. (Motion seconded by Dr. Edwin Lukaszewski, Cook County.)

PRESIDENT: Is there discussion?

DR. C. A. NORBERG, Cook County: It appears to me that we are referring a very important portion of this report to the Council again. As I understand, the Council consists of 16 men. The word *Council* appears very prominently in the constitution and by-laws. Here we are putting more power in the hands of a small group. I would object to having more power in the hands of the Council.

PRESIDENT: Is there further discussion?

DR. E. V. MCCARTHY, Cook County: Would the chairman be kind enough to read again the last portion of the report?

DR. REAVLEY: One reason for that particular wording: The state society is in a period of reorganization. There is to be an executive secretary, a public relations director, an editor; there are to be new employees. As I understand, none of them has been hired as yet. It was very hard to establish the functions of the Springfield office. Our idea was that there would be a legislative office in Springfield, and some other functions would be carried on there. We did not want to spell it out until we had fully decided what the functions would be.

DR. NORBERG: I still do not understand why we have to give this very important question to the

Council. Why cannot the House of Delegates decide what function this office will have? Why not have the legislative office in one location? It could be voted on by the House of Delegates.

Dr. C. Epsteen, Cook County: It seems to me that every organization must have some kind of executive committee to perform the functions of that organization when the organization is not in session. That executive committee here is the Council. The Council is directed to run the business during the interim. I do not see why there is any discussion. It is up to the Council to run the organization. I think it should be voted on as proposed by the committee.

Dr. White, Henry County: That is exactly what I was going to say.

Dr. Epsteen: I move the question. (Motion seconded and carried.)

President: The motion to adopt the report as presented is carried.

Dr. Reavley: This report is respectfully submitted and signed by Drs. Norbury, White, Vaughn, Oldfield, and Reavley.

President: Thank you, Dr. Reavley, for a job well done. The chair attended some of the sessions this morning and many of the views expressed were extremely convincing. I congratulate them on bringing in this report. As a matter of fact, I feel it is the duty of the president, since there seems to be some confusion in the minds of the delegates regarding the function of the Council and the House Delegates, to remind you and to remind the doctor who objected to the Council's taking certain prerogatives, that the views expressed by Dr. Epsteen are certainly correct; if you want to revise any of the constitutional provisions, you have that privilege at the May meeting. If it is felt that the Council is usurping functions that belong to the House of Delegates, I would advise you to come in with some proposals for revision. They will be referred to a reference committee, where you will get full discussion. The Council cannot be infallible. It works for the common good, for the majority. The majority, as represented by the House of Delegates, should have a full voice in everything.

I will deviate from the agenda. Dr. Julius M. Kowalski of Bureau County has asked for the privilege of the floor.

Dr. J. M. Kowalski: I would like to call the delegates' attention to the Fourth Conference on Obstetrics and Maternal Welfare of the Illinois Committee on Maternal and Infant Welfare, which will be held on February 3, 4, and 5, in the Pere Marquette Hotel, Peoria. This meeting has the endorsement of pediatricians, obstetricians, and gynecologists. Your officers, Dr. O'Neill, president, Dr. Hesseltine, president-elect, and Dr. Montgomery, chairman of the Council, will attend. I would urge that all of you attend this meeting.

President: We will now hear the report of the Committee on the Rogers, Slade, and Hill Report and the Report of the Ad Hoc Committee, Dr. John R. Wolff, chairman.

Committee to Consider Rogers, Slade, Hill Report and the Report of the Ad Hoc Committee

Your Reference Committee E has been asked to consider and report to you on the Rogers, Slade, and Hill report (Edlund report) and the Report of the Ad Hoc Committee. At the meeting of the House of Delegates last night, specific portions of this report were assigned to this reference committee and will be presented to you for your action. The committee met in Parlor D at 8 a.m. Your committee is appreciative of the interest of the many delegates who attended this meeting and is indeed thankful to them for helping us formulate our views. As chairman, I would like to thank the individual members of this committee who joined with me so early this morning and have worked together so wholeheartedly in preparing this report for the House of Delegates.

Your committee feels that in essence the Edlund study has been a deserving one. Just as medicine itself is constantly changing due to new discoveries and new horizons, so must the organization and detailed mechanics of a medical society. Our officers and councilors, busy in their own practices, devote a tremendous amount of energy to the workings of the Illinois State Medical Society. Through their leadership and that of the House of Delegates many improvements have been made to bring competent medical care to the people of Illinois. Each of us can think of many improvements and many good deeds that have been accomplished within our organization.

Before considering this critical material, it would be well for each of us to count our blessings. We would then realize that they are many and far-reaching. This does not mean that your committee wants the status quo. Nor do you. We all want progress where it is needed, and yet wish

to retain all that has helped bring us to the point we have reached today. We also recognize that each change must proceed in a step-by-step fashion. Rapid progress is best accomplished if we race, like the proverbial turtle, in a slow-but-sure fashion.

Now may I refer you to our first item on page 6 of the Edlund report. Question: Should the administrator be an M.D. or a layman? We feel that the administrator (executive director) must be an individual hired, employed and responsible to the Council of this society. We recommend that a high-grade, well-paid executive director, preferably an M.D., be so employed.

Dr. Wolff: I move the adoption of this portion of the report. (Motion seconded.)

Dr. White, Henry County: Do I understand that much effort will be made to find an M.D. or an executive director who might have had several years in preparation for this sort of work? It might make a difference in the Ad Hoc Committee's actions in the future regarding that executive. It might be difficult to find doctors who have been trained in executive work. We have one sitting on the platform who is a honey, but he does not want to work for us. There are many fine executives who have been trained as medical executives.

Dr. Wolff: The committee is in full agreement with Dr. White. We are interested in finding a good executive. If he is a medical man with executive ability, so much the better. If he is a good executive with medical knowledge, may be he is our man. We feel it must be left open so we can hire the best man available.

Dr. F. Garm Norbury, Morgan County: I would like to refer to one thing. The American College of Physicians has had for many years an excellent lay executive who has done an excellent job. When the present executive retires, they are recommending that an M.D. be hired for that position.

Dr. G. Kaiser, Cook County: It seems that medicine is a profession and it is a calling. To be a physician makes a change in the individual. His outlook is different from that of a lay executive. I doubt that a lay execeutive will ever have the same point of view as a physician. For this reason I think it would be wise to select a physician for this task. I am sure there are men of Dr. Lull's capabilities.

President: The question is called for. (The motion to adopt this portion of the report is carried.) You may proceed, Dr. Wolff.

Page 9, the last paragraph: Serve and strengthen the component societies.

The state society should assist the county society in every way possible, but should not dictate it. The activity of the county society depends upon the members thereof and their interests in medical affairs, local, state, and national. It is desirable to have better liaison between the state officers and the county society. The Council should give its utmost consideration to the employment of field administrators as an aid in this regard.

Dr. Wolff: I move the adoption of this portion of the report. (Motion seconded by Dr. Robert E. Heerens, Rockford.)

Dr. McCarthy, Cook County: Will you define field administrators?

Dr. Wolff: In another portion of the handbook, I cannot recall the page, is the subject of field administrators. That was assigned as a prerogative of the Council and not given to our committee. The field administrators are to be assistants to the executive administrator, whose duty it will be to accomplish the necessary liaison work between the doctors at the crossroads and the state medical society. They would be employees of the state society.

Dr. M. R. Saxon, Kendall County: I would like to urge the committee on that portion of this report to properly and more completely spell out or integrate recommendations to the Constitution and By-laws Committee to better define, "how to serve and strengthen the work of the component societies." The work of the component societies in the constitution and by-laws is largely omitted and wrong. It does not clearly define the functions and limitations of the county society. It should spell out things that are mandatory. Last year we of the county medical society had a resolution to this effect. I am sure I speak for all the county medical societies in advocating such a change.

President: The chairman of the Council would like to make a statement.

Dr. B. E. Montgomery: I think you will find under our setup that the county medical societies are autonomous; they make their own rules, and they go by them; they become part of the state medical society only as they wish to participate. There is only one thing that is mandatory and that

is that the county society constitution and by-laws must not be in conflict with the state society nor the American Medical Association.

Dr. Saxon: I know we have all thought about this term, field administrator. My society thinks that it would be better to break down the councilor districts into smaller units and that the work that would be done by the field administrator could be done by the councilor. I would like some thought to be given to that. It seems to me it would be much better to break down the councilor districts and increase the number of councilors. If nine councilors was the proper number for this society in 1870 when it was formed, it needs more than 16 now. If we increase the size of the Council and decrease the size of the district, this work could be done more efficiently and more practically than by field administrators.

President: Thank you for your information.

Dr. Bell, Macon County: One of the big problems today is the same as it was years ago — to reach the rank and file. You can write them and invite them, and they do not come. You can reach them only through some one hired to do it. I think the idea of making this the work of a field administrator is to have some one who is hired to do the work and if he does not, he can be fired.

President: Are you ready for the question on this portion of the report? (Motion carried.) Proceed, Dr. Wolff.

Page 15: Prescription.

The reference committee believes that this state society is an excellent one and that the officers, past and present, have created an enviable record of service and accomplishment. Because of the society's constant growth, we should obtain whatever additional facilities and top-flight administrative personnel seem necessary and desirable.

Additional dues of $10 per member were voted by the House of Delegates in May, 1959. An additional $100,000 is thus available to our organization for aiding its growth during 1960.

Dr. Wolff: I move the adoption of this portion of the report. (Motion seconded.)

Dr. R. E. Heerens, Winnebago County: Do I understand that this reference committee is also considering the Ad Hoc Committee's comment on these portions? In the Ad Hoe Committee report they disagreed with the statement in the handbook, and they disagreed with you. If you disagree, I think you should so state.

Dr. Wolff: Where there were conflicting statements, we put them together. That is what we tried to do.

(Motion carried.)

Page 18: Suggestion IV. The handbook.

We offer the suggestion that all reports, resolutions, names of delegates, reference committees, etc. be printed as a supplement to the April issue of the Illinois Medical Journal and mailed to all members.

Dr. Wolff: I move the adoption of this portion of the report. (Motion seconded and carried.)

Page 19: Suggestion V. County or District Caucuses.

The suggestion to hold county or district caucuses for discussion in advance of the annual meeting is an excellent one. It is being done in many districts and should be encouraged in all.

Dr. Wolff: I move the adoption of this portion of the report. (Motion seconded and carried.)

Page 29: Suggestion XIII.

Although comments on this suggestion will be made to you by the Constitution and By-laws Reference Committee, there was considerable discussion by many guests attending our meeting, who asked us to comment on the policy of separating the Public Relations Committee from that of the Committee on Medical Services. We do agree that a public relations director should be employed and that his duties should be separate from those of the Committee on Medical Services. This portion of our report is one of suggestion and will require no action since we bow to the prerogatives of the Reference Committee on Constitution and By-laws.

President: The chair is in agreement. Is the House in agreement? Proceed, Dr. Wolff.

Page 37: Suggestion XVI.

Postgraduate education we heartily endorse.

Dr. Wolff: I move the adoption of this portion of the report. (Motion seconded and carried.)

Page 37: Suggestion XVII.

We agree the Illinois State Medical Society must assume its leadership in coordinating all the activities concerning postgraduate education in this state. However, we must proceed slowly and surely, and the exact technique had best be left to the discretion of the Committee on Postgraduate Education.

Dr. Wolff: I move the adoption of this portion of the report. (Motion seconded and carried.)

Page 38: Suggestion XVIII.

This suggestion is being carried out now by a

committee of the society. We agree that greater continuity is desirable.

Dr. Wolff: I move the adoption of this portion of the report. (Motion seconded and carried.)

Page 42: Suggestion XXV.

Dues — This has already been accomplished.

Budget — We wish to comment in favor of this suggestion and its publication in the Journal.

Dr. Wolff: I move the adoption of this portion of the report. (Motion seconded and carried.)

Page 43: Suggestion XXXII.

Yearly Objectives. We believe this is desirable.

Dr. Wolff: I move the adoption of this portion of the report. (Motion seconded and carried.)

I would like to thank you, the members of this august body, for your kindness and tolerance during this presentation.

This report is signed by Drs. George B. Callahan, Norman L. Sheehe, William Whiting, Darrell H. Trumpe, Noel G. Shaw, and John R. Wolff, chairman. I move the adoption of the report as a whole. (Motion seconded and carried.)

President: Thank you Dr. Wolff for a fine report.

Dr. Noel G. Shaw, Cook County: Though I signed the report, is it not in order to express the thanks of the House of Delegates to the Ad Hoc Committee, Drs. Hesseltine, O'Neill and Hamilton? I so move. (Motion seconded by many.)

President: Dr. Lee Hamm, please take the chair and put the motion to a vote. (The motion was carried.)

President: A special reference committee was appointed last night by the chair to consider the subject of medical care for the over-65 group. It was headed by Dr. Paul Dailey at the request of Dr. Cannady, who did not wish to serve as chairman. We will now hear the report.

Reference Committee No. 4. Medical Care of Those 65 and Over

Reference Committee No. 4 met in relation to the questionnaire concerning the medical care of those 65 and over, submitted by the Committee on Medical Service and Public Relations.

Information obtained from the questionnaire was reviewed and discussed, and much valuable information was given to those in attendance. The results will not be made public until released by the Council. It was emphasized that this questionnaire was not a ballot but a means of securing information.

The following points of view were expressed:

1. A considerable number of physicians were found poorly informed on the meaning and background of the questionnaire.

2. Disagreement was expressed as to whether this was the correct method of securing the information.

3. Dr. Ford, representing the Rockford plan, and Robert Evans, representing the Chicago plan, discussed the role of Blue Shield in the projected coverage. Both stated that the fee schedule of any proposed plan must be approved by the Illinois State Medical Society before implementation by Blue Shield.

The differences between indemnity and service plans were explained.

Further, it was stated that any new plan implementing the action of the House of Delegates would be full payment for those within the prescribed lower income and asset group; the indemnity principle would apply for all those above the approved income and asset limits.

It was further stated that no new plan could be placed in operation in any county without approval of at least 51 per cent of the individual physicians in that county.

4. Resubmission of a simplified questionnaire regarding approval or disapproval of the plan as approved by the House of Delegates in May, 1959, was suggested by many of those participating in the committee hearing.

After careful consideration the recommendations of the reference committee are as follows:

1. That the Committee on Medical Service and Public Relations be instructed to send to the membership of the Illinois State Medical Society a copy of the resolution adopted by the House of Delegates (Illinois State Medical Society) in May, 1959, regarding financing medical care for those 65 and over.

2. As a result of the poll by the Committee on Medical Service and Public Relations presented to this committee, it is indicated that there is interest in a special program to provide benefits on a payment in full basis to that segment of the population 65 years of age and over with limited income and resources.

We recommend that the Council of the Illinois State Medical Society prepare a program including fee schedules and suggested income ceilings as well as net worth limits to be presented to the membership for their individual consideration.

3. We recommend that a full discussion of this problem be held by each county medical society after receiving pertinent information from the Council.

Respectfully submitted,

(Signed) E. W. Cannady, M.D.
George Turner, M.D.
E. T. McEnery, M.D.
C. K. Wells, M.D.
Paul A. Dailey, M.D., Chairman

Dr. Dailey: I move the adoption of this report. (Motion seconded.)

President: Is there discussion?

Dr. Montgomery: In the second paragraph of this report it says, "The results will not be made public until released by the Council." There is nothing secret about this report. I presume those results were discussed at the committee meeting. The reason is that the results are not yet completed. I did not want anybody to misunderstand that the Council was trying to keep anything secret. The present report was supposed to give all the information we had as a result of the questionnaire.

President: Ballots are still coming in to the state office. That is the reason for not revealing any of the figures. Is there further discussion?

Dr. P. T. Dolan, Kane County: The report of the reference committee indicates that there is *interest* in this program. This is a word that philosophically cannot be well defined. It is undefinable because that sort of prepared program should be presented to the membership on the basis of existence or non-existence. This is not good or sound procedure in a matter in which the society is asked to make a profound change. The delegates from our district have been here to request a reconsideration. The objections are

1. That the doctors had insufficient knowledge of what was meant by Supplementary Report H;
2. That consideration of implications were insufficiently discussed. It was felt that a sound decision could not be reached.
3. That consideration of our own ability to gauge and measure the demand for a proper supply of medical services for others was not sufficiently discussed;
4. Consideration of ability of others to place a value, however reduced, upon our services was not sufficiently discussed.

At any rate these were the objections to the questionnaire. This is the basic reason why a single proposed plan will not correct the situation. The membership will not be able by answering *yes* or *no* to the questionnaire to interpret all the implications.

As to the usefulness of this proposed action to alleviate political pressure, it is understood that the purpose of the proposed action is to provide certain services for the aged indigent through an especially favorable insurance contract, thus lessening the alleged urgency of the government's providing similar services, in the hope that this measure will influence politicians (and giant bureau-builders) not to press for Forand-type legislation.

It is understood that the proposed action is to be implemented by the practitioner's acceptance of fees set by a third agency according to this agency's notion of the patient's wants, needs, and ability to pay.

It is further understood that a schedule of standardized fees (and standardized disease states) is to be used in determining payments to the practitioner by the third party.

President: If you can summarize briefly, I think the House would appreciate it. Let the House be acquainted with the position of your medical society which you are representing.

Dr. C. Portes, Cook County: I do not believe that the gentleman from Kane County has clarified it too well. His first statement definitely needs no argument. We must do something to combat the Forand bill or any other bill. As to your feeling that it is already too late, we are at a crisis. This is not going to brush over very lightly. Time is of the essence. We must do something to combat such legislation. We must decide on a fee to show the public we are not concerned with money but with public health.

Dr. White, Henry County: I think, too, there should be a little clarification of what we have been talking about. It happened that last May I, representing Henry County, brought in a resolution which was on the care of the aged. At that time I would remind you that we talked about this in this manner and the reason for it. First, at the Minneapolis meeting of the A.M.A. we were told by those who were close to the situation that the Forand bill was very likely to go far unless American medicine did something. We had been fighting, and we have successfully fought. At each meeting of the House of Delegates of the A.M.A. since that time we have been reminded that the

Forand bill is still waiting for something that we should do to relieve the situation of the needy or those aged over 65. On that score we brought in a resolution which was to this effect, that we would accept, for we know that the government is only interested in full payment of the bill. We in Illinois, as individuals, are opposed to service contracts. However, we are only one of six or seven Blue Shield plans which are not using service contracts; that is out of some 67 contracts over the United States.This was mentioned then. If we are going to be effective in combatting the Forand bill, we must make this group a service group. We have likewise heard spelled out or have asked to have spelled out, what is the net worth of an individual patient entitled to such a contract. Blue Shield has told us that it must be actuarially sound, therefore, we must name some figure that we would be willing to accept. Why should we accept it? Gentlemen, I will tell you why. For 65 years these people have lived with the idea that they have paid their way, and they were proud to be able to do so. They reach a time in their lives when insurance costs have mounted, and if they cannot carry insurance to pay for medical care, they are objects of charity. We, as representatives of American medicine, know that someone must care for these people and that someone would, that either insurance or the government is going to pay so these people of 65 and over in the low income group will be able to maintain their dignity and their self respect and not be objects of charity.

Dr. W. K. Ford, Winnebago County: I would like to bring up a little point of clarification. In the discussion before the reference committee, this questionnaire was spoken of as a poll. During the latter part of the meeting Dr. Cannady said this was a questionnaire for opinion. I would like to ask Dr. Dailey whether he considers this a poll or is a poll to be taken.

Dr. Cannady: It is our understanding that this questionnaire was merely for informational purposes; it was not a poll. I might explain a little more about recommendation No. 2. At first in the committee meeting the committee decided to suggest that a poll be taken again merely to ask "yes" or "no" if the membership would approve the action of the Council and then prepare a simple program. But it was pointed out, and I thought very well pointed out, that the membership of the state society would appreciate very much more knowing what plan they would be voting on. That is why the committee recommended that the Council be authorized to prepare a definite fee schedule and send it to Blue Shield and then send it to every member of the state society and ask whether he would or would not participate.

Dr. Norberg, Cook County: The other night we entertained at dinner the five congressmen from our area. Though we did not plan to discuss the Forand bill, our speaker, Herbert Schmitz, talked all around it and did not mention the Forand bill. Then the five congressmen were asked to express an opinion. What we know is that something has to be done. It is not the doctors' fault; it is the high cost of hospitalization. The doctors' bills are a small part of the cost. The Social Security Act has been changed every election year since it was inaugurated. It seems possible that the doctors' part of that will be cut off and hospitalization will go over until the next election. These men have to consider more than just the doctors' part. They come up with a plan. Congress asked, "How are you going to take care of these people?" We must come up with a plan to take care of these people. I do not think we should quibble whether it is two or three dollars per call, we must get in line somehow.

Dr. T. Van Dellen, Cook County: There is one aspect of this bill that they have neglected to mention, and it is an argument against it. It is the change in the tax schedule. In 1968 the tax will be 7⅛% of the amount of self-employment income. It is what people who are self-employed will have to pay. It is going to cost us a lot of money.

Dr. W. A. Moore, Richland County: I am a member of the legislature and a member of the legislative committee. I am a good friend of Senator Douglas. I have talked about this Forand bill for years. Voting for or against it is not going to get the politician a lot of votes, but men like Senator Douglas are concerned in providing medical care for people who are not getting it. We are not going to oppose medical care for people who do not get it. This approach of the A.M.A. I am in favor of, but that is only a partial source. Industry has to stop its compulsory retirement of old people. It has to use them and let them keep on working as long as they can. That is what old people want, self respect and usefulness. Secondly, labor has to have a lower minimum wage scale so these people can work after 65. You will be surprised how many labor people would like to see a modification of this. You can understand how many industries

would like to have these old people working. This is a medical economics problem; it will not be solved by the doctors alone. It is a big factor. We should have liaison groups with industry, labor, and health organizations.

Dr. McCarthy, Cook County: I think it makes very little difference what the doctors do regarding the aging program, because the voting strength of medicine in itself is too small. If we can create an educational impact upon the public, our chances should be better, but this, of course, requires solidarity of thought and action. Those aging people now receiving so-called "social security" would undoubtedly throw their support to the Forand bill, and it seems to me quite logical that all those who might otherwise participate in the support of these people would also be for the bill.

No practicing politician is going to shoot Santa Claus, and promises regarding the aging will be almost irresistible vote traps from here on in; I expect most of the politicians to make the most of it. It seems to me that hastily trying to perfect a medical care program for the aged under the prodding of a governmental threat carries with it the implication that heretofore we have been negligent in our concern about these people and that we are doing something now only because the government is forcing us to do it. The one-worlders and welfare-staters will make the most of this. The creation of a reduced fee program would be widely regarded as evidence of our disinterest heretofore.

Are dentists cutting their fees? Are undertakers cutting theirs? Does the gas company reduce rates to these people?

Adoption of the program we have been discussing will go a long way toward reading medicine out of the free enterprise system and will constitute an irrevocable step further into the field of socialism. The way to win an issue is to fight — not to concede defeat.

Dr. W. P. Plassman, Washington County: I believe we can get to this by proposing something practical. Let us get voluntary health insurance which is prepaid at 65; make the premiums very attractive to everyone, so that at 65 everyone is taken care of by voluntary health insurance. I would propose that we start to work on such a plan.

President: The chair would like to ask the privilege of the floor for Dr. Hamilton. I would like him to give a report of the questionnaire so far as he has it. It is not a final report. Since it has been brought up and has left some conjecture in your mind, I think you should have it.

Dr. N. G. Shaw, Cook County: I would like to make a report or two about several different points. In any future mailing on this program, I hope the covering letter will cover the thinking and the action taken in the House of Delegates in May, 1959. I think the person who writes the covering letter has more knowledge than the person reading it. The House of Delegates asked last May that a poll be taken. A yes or no poll can be taken, but a covering letter or some detailed information has to be sent out. I still think that a poll is the democratic way to handle it. If the men want to sign it they can; if not, they do not have to. We were asked to help not the indigent over 65 because they are already taken care of. This was to help those in the limited income group. If we regard these payments by Blue Shield as payment in full, we have made some progress. If we consider these payments only as indemnity toward the entire fee, then I do not think we have made a contribution toward handling this problem.

We tried to point out last May that Blue Shield should be the arbiter. None of us wants to see these people in our community who are eligible for low cost insurance left out. I doubt very much if this House should make up a fee schedule. We should leave it up to the officers of Blue Shield. You remember when we wrote this recommendation last May, we tried to ask the cooperation of the hospital administrators on this problem; that was stricken out. We simply asked their help. It was worded a little more strongly at first. I would like to point out that two weeks ago I talked to one of the hospital administrators who is very prominent in the Hospital Council, and he had not even heard of our proposal.

Dr. Lukaszewski, Cook County: Before Dr. Hamilton gives his report, I move we go into executive session.

President: Is there support for the motion? (Motion seconded.) Are you ready for the question? (Motion was lost.) It is so ordered and you may proceed, Dr. Hamilton.

Dr. E. S. Hamilton: Will you tell me what you would like to have me say?

President: It was our belief that you should give to the House the principal figures of the questionnaire insofar as they have been tabulated.

Dr. Hamilton: I would request that those who get them do not make them public property.

(Dr. Hamilton gave progress report.)

PRESIDENT: Very well done, Dr. Hamilton; thank you very much. The chair has allowed the greatest latitude in discussing the report of the reference committee. We do not intend to shut anyone off. Is there anything more that is pertinent to the report?

DR. A. J. SULLIVAN, Cook County: I support the recommendations of the reference committee. I think we are being stampeded in a sense into a sort of hysteria. Everybody seems to forget that the Forand bill cannot become an active legislative act or be enforced without the cooperation of the doctors. No doctor is forced to participate in any plan that the Forand bill will legislate. The final outcome is in your hands. If you do not wish to participate, you do not have to.

DR. DOLAN: I would like the privilege of the floor to answer the doctor.

PRESIDENT: Granted.

DR. DOLAN: Dr. Hamilton did not point out that the county that was the exception to the rule was Kane County. We have a series of meetings in Kane County that are different from all other counties. We gave over our county society meeting exclusively to a discussion of matters of this sort. I think the discussion has made a difference in the report from our county. This is precisely the report I wish to make. Any questionnaire has to be thought-provoking. This did provoke thought on implications and what we are going to do.

I am interested only in the principles involved. We know, or at least ought to know that appeasement of the politician is not going to work. If he wants to get into the act, any small effort will not prevent him. We are mature. We have watched the change in American politics from a democratic to a socialistic form.

As to principle, if we are to accept the proposal, we would accept fees set by a third agency. An agency other than the individual physician is a third agency regardless of its mask of sanctimonious purpose, regardless of stated limited application, regardless of its fabrication by a medical agency, regardless of previous acceptance of similar fees. In other respects this can be interpreted to mean, regardless of whether it is fair or not, that we believe in standardized disease states. This is what the socialist wants, standardized disease states treatable by standardized methods of treatment by standardized skills. How can this be accomplished? How can diseases be treated by standardized skills? It cannot be otherwise. It means that we yield to the arguments of certain vindictive and prominent socialists who have maintained this proposition to the public in a large political sense. It means that we admit to a false position maintained for many, many decades. More important, it means that we are ready to yield our integrity and our responsibility for the health of our patients to cheap political pressure, if we accept standardized methods of treatment that one case of pneumonia is like another; that one case of typhoid is like another. To accept the notion that we, a professional society, can determine the medical wants and desires of even a small segment of society, means that we accept; also that we can determine the ability of this segment to pay for medical services means we accept the most central, as well as the most untenable of socialist principles. If we accept the notion that we, a profession, are able at our own expense to fill certain needs alleged to be present by the politically ambitious, and to the satisfaction of said politician or bureaucrat, is to give over our minds to the literal belief in fairy tales. These politicians want to get into medicine. They want to graft onto medical fees; that is the only purpose. They will continue to be dissatisfied with any proposal we can make. This is also to give to the socialists a live example of a group lacking the intelligence to analyze one of the most common maneuvers ever used by the politically ambitious to gain arbitrary power. This pattern is not new. It is done over and over again. He says something is needed. There is something the public is not getting enough of. Are you against the public getting something? We must be an awfully immature group not to be able to see through this. It has occurred again and again. When are we going to learn? Are we going to accept the notion that, frightened by the threat of being socialized, we are obliged to socialize ourselves, obliged to place ourselves in an obviously untenable position in order to solve alleged problems not solvable by second parties. We betray a lack of confidence in our own ability to seek and find practical solutions. We admit a lack of knowledge of the worth of our own medical traditions.

As to the solution, there are many, many superior to the Blue Shield plan. There are good solutions much more sound than the one they propose.

PRESIDENT: Thank you Dr. Dolan. The chair recognizes Dr. Percy E. Hopkins.

DR. P. E. HOPKINS: I would hope that this body

would vote in favor of the reference committee's report. I would remind you that reference was made to the questionnaire which referred only to the medical society's sponsoring a plan, the Blue Shield plan that can operate only under the sponsorship of the medical society. Dr. Hamilton's report has indicated an active and wholesome interest in the manner of providing for service to those past 65. I would remind you that Blue Shield must set up a fee schedule. Any service plan would be set up by representatives of the medical profession of county societies sitting on Boards of Trustees in the Blue Shield office or any executive director. These would be fees that would be arrived at by members of the medical society. Furthermore, Blue Shield plans would have to go out over the counties and obtain the consent of more than 50% of the doctors residing in that county before they could begin to sell contracts in that county. I would have no fear of the fee situation. I hope the House will accept Dr. Dailey's report.

Dr. C. J. Weigel, Cook County: I move the previous question. (Seconded by many. The motion was carried.)

Dr. Dailey: I move the report of the reference committee be accepted. (Motion seconded by many and carried.)

In the September issue of the Illinois Medical Journal there is an article entitled, "Practical Approaches to the Problem of Aging" by Dr. Edward W. Cannady. I would make the suggestion that each of you read this article, for it gives in very fine form all the things discussed this morning. I must take exception to Dr. Dolan's expression of political pressure. I think anyone familiar with the problem of aging knows we are not running away from the politicians. We are still doctors, still rendering service to people who need help. I would also remind Dr. Dolan that any county that does not wish to have this Blue Shield plan need not accept it.

President: Thank you Dr. Dailey for your report.

The chair recognizes Dr. C. Elliott Bell, chairman of the Credentials Committee.

Dr. Bell: At the first meeting the Credentials Committee certified 31 officers, councilors, past president, and A.M.A. delegates, 76 downstate members and 62 Cook County delegates, a total of 169. At the second meeting it certified 32 officers, councilors, past presidents and A.M.A. delegates, 74 downstate members, 58 Cook County delegates, a total of 164. I move that this report be accepted. It is signed by Drs. Patrick H. McNulty, Carl E. Sibilsky, William H. Walton, and C. Elliott Bell, chairman. (Motion seconded and carried.)

Dr. C. Portes, Cook County: May I take this opportunity to announce that the First Cancer Congress to be held in the State of Illinois will be held in Springfield on March 9, 10, 11. We will have speakers from all over the country. I would like to invite everyone to come.

President: The next item on the agenda is the report of the Reference Committee on Changes in the Constitution and By-laws, and Miscellaneous Business. Dr. William H. Schowengerdt, Chairman. No final action on constitution and by-laws changes can be taken at this meeting. It is only at the May meeting that we can make them. The report is informational only. You can discuss it, but no action can be taken.

Report of the Reference Committee on Changes in the Constitution and By-laws; and Miscellaneous Business

Your committee met at 8 a.m., December 13, in the Lincoln Room on the 18th Floor, and began deliberation of the matters referred to it. The meeting was attended by the members of the state medical society's Committee on Constitution and By-laws and approximately 50 members of the House of Delegates.

The following is the consensus of the reference committee:

Recommendation I, appearing on Page 6 of the Rogers, Slade and Hill survey, which reads, "Look forward to employing a high-grade, well-paid administrator as the Society's executive leader. Amend the constitution and by-laws to make this possible, and to remove existing limitations on the search." Your reference committee recommends approval.

Dr. W. H. Schowengerdt: I move the adoption of this portion of the report. (Motion seconded and carried.)

Recommendation II, Page 6, which reads, "Abolish ultimately the elective office of secretary-treasurer. If at the start this seems too revolutionary, take it in steps instead of all at one time." Your committee recommends that this recommendation be not approved. The consensus of the members of the committee was that the State requires there be a secretary-treasurer for each organization and

that he render a report as required by the State of Illinois.

Dr. Schowengerdt: I move the adoption of this portion of the report. (Motion seconded by Dr. Robert E. Heerens, Winnebago County, and carried.)

Suggestion I, page 10, which reads, "Add to Article II of the Constitution entitled, 'Purposes of the society,' a declaration that an objective of the State Society is to serve and strengthen component County Societies." Your committee recommends that this suggestion be approved with the addition of the word "thereby," so that the purpose of the society will read as follows: "The objective of the state society is to serve and thereby strengthen component county societies." Your committee also recommends that this change by approved and referred to the Constitution and By-laws Committee for their implementation.

Dr. Schowengerdt: I move the approval of this portion of the report. (Motion seconded and carried.)

Suggestion II, page 10, which reads, "Add to the same Article II that an objective of the Society is to improve medical care for the people of Illinois with the least financial burden on the individual." Your reference committee recommends disapproval of this suggestion.

Dr. Schowengerdt: I move the adoption of this portion of the report. (Motion seconded and carried.)

Suggestion XIII, page 29, which reads, "Consider dividing the Constitutional Committee on Medical Services and Public Relations into two Committees, one on Medical Services, the other on Public and Professional Relations. Take steps, nevertheless, through the Council or in some other manner such as a joint chairmanship, to see that the activities of the two Committees are coordinated." Your committee recognizes that a resolution on this subject was referred to the Council at the last annual meeting, and, therefore, recommends that action on this suggestion be deferred, and that the Council be requested to report on action taken concerning this resolution.

Dr. Schowengerdt: I move the adoption of this portion of the report. (Motion seconded and carried.)

Suggestion XXX, page 43, which reads, "A Speaker and Vice-Speaker, with terms limited, to save burdens on the President at the Annual Meeting." Your committee recommends that this suggestion be adopted with the change read, "presiding officer and alternate presiding officer, with terms limited, to save burdens on the president at the annual meeting."

Dr. Schowengerdt: I move the adoption of this portion of the report. (Motion seconded.)

Dr. White, Henry County: Why are you not using the word speaker?

Dr. Schowengerdt: The word speaker represents that he is speaking for all of us without regard to individual views or opposition. The words presiding officer mean merely a man who presides at the meeting. (Motion carried.)

All of you have been given copies of the proposed changes in the constitution. The committee has considered each and recommends the following action:

"Article V. Change (b) to read: "*the officers of the society*" Delete (e).

Dr. Schowengerdt: The committee recommends approval and I so move. (Motion seconded and carried.)

Article VI, Section 1. Substitute "presiding officer and alternate presiding officer" for the words, "The speaker and vice-speaker."

Dr. Schowengerdt: I move the adoption of this portion of the report. (Motion seconded.)

Dr. Norberg, Cook County: Does that mean we accept the entire section?

Dr. Schowengerdt: This is Article VI, Section 1.

Dr. Norberg: These are all referred back to the Constitution and By-laws Committee.

Dr. Schowengerdt: May I read this again? The only change is to substitute presiding officer and alternate presiding officer for the words speaker and vice-speaker.

Dr. Norberg: This mimeographed sheet actually contains the changes that are being proposed in the constitution and by-laws. Here it says, "Article VI, Section 1." If we approve this recommendation, just changing little words, does it mean we are approving the entire section?

President: The chair recognizes Dr. Andrew J. Brislen, Cook County.

Dr. A. J. Brislen: There seems to be confusion among some of the delegates. The printed galley proof is actually the constitution as it currently exists with the amendments as approved in May, 1959. There is nothing that we can do to it. It is currently the law of this society. The mimeographed sheets were made later; they are pro-

posed amendments to this constitution. They have been currently referred to this committee for discussion. They are presented here with or without committee's approval. They will be passed to the Constitution and By-laws Committee to be presented for action in May, 1960. All that the committee is reporting on is this mimeographed sheet, which contains proposed amendments that are being changed to your wish before they are presented for action in May, 1960.

Dr. Norberg: I do not feel that this section should be gone over so quickly and hastily. It refers to the Council. It is my opinion and it has been mentioned by many people, that the Council has too many powers. Just reading this over . . .

President: You are out of order.

Dr. Norberg: I do not understand.

President: These are simply discussions of what the committee brought before us. Are you ready for the question on the approval of Article VI, Section 1? (Motion carried.)

Article VI, Section 2. Add "as authorized by the House of Delegates," at the end of the sentence. We recommend approval of this portion of the report.

Dr. Schowengerdt: I so move. (Motion seconded and carried.)

Article V. approved.

Article VI, Sections 2, 3, 4, 5, 6, 7 to become respectively Sections 3, 4, 5, 6, 7, and 8.

Dr. Schowengerdt: I move the adoption of this portion of the report. (Motion seconded and carried.)

Article IX, Section 1 and Section a. Substitute "presiding officer and alternate presiding officer" for "speaker and vice-speaker." Also in Section 2, add, following the words, "alternate presiding officer," the phrase "who should be versed in parliamentary procedure."

Dr. White, Henry County: I am still terribly confused. I do not understand why, when the A.M.A. has a speaker and vice-speaker and many, many medical societies have a speaker and vice-speaker, why we want to use just another name. Why do we not call it speaker and vice-speaker. You tried to tell me a moment ago but I do not understand it.

Dr. Schowengerdt: It was our consensus, after listening to all the discussion this morning, that this was what they wished.

Dr. White: May be it is. What does the House want?

Dr Schowengerdt: Actually the presiding officer will have no power, and he does not have a vote. He merely presides at the meeting. He is not the speaker because he does not speak for you and me as delegates.

Dr. Montgomery: The presiding officer and alternate presiding officer shall be elected in the House of Delegates. They are members of the House and therefore would have a vote.

Dr. McCarthy, Cook County: Some reference was made here to an alternate who was versed in parliamentary procedure. No criteria were established for this person. How does one go about selecting a man who is versed in parliamentary procedure?

President: We are having discussion as to the formality of the report. I terminate the discussion.

Dr. Schowengerdt: I move that portion of the report be adopted. The words to be added are, "who should be versed in parliamentary procedure." Roberts' Rules of Order could be studied. (Motion seconded and carried.)

We go now to the By-laws; Chapter II, Section 1. The committee recommends approval.

Dr. Schowengerdt: I so move. (Motion seconded and carried.)

Chapter VII, Section 1. We recommend approval.

Dr. Schowengerdt: I move the adoption of this portion of the report. (Motion seconded and carried.)

Chapter VII, Section 4. This was approved in principle, but to read as follows: "The presiding officer shall preside at the meetings of the House of Delegates, and shall perform such duties as custom and parliamentary usage require. He shall announce reference committees as appointed by the president of the Society and chairman of the Council."

Dr. Schowengerdt: I move that this portion of the report be adopted. (Motion seconded and carried.)

Chapter VII, Section 5. Substitute the words "alternate presiding officer" for vice-speaker, and the word "presiding officer" for speaker.

Dr. Schowengerdt: I move the adoption of this portion of the report. (Motion seconded and carried.)

Chapter VII, Section 6. Approved.

Dr. Schowengerdt: The committee recommends approval of the section as written, and I so move. (Motion seconded.)

PRESIDENT: It was stated in the original part of the report that the office of secretary-treasurer be not deleted, but be retained by the requirement of Illinois state law. This merely states his duties. (Motion carried.)

Chapter VIII, Section 1. Delete "The secretary of the Society shall be secretary of the Council."

DR. SCHOWENGERDT: The committee recommends approval of this portion of the report, and I so move. (Motion seconded.)

DR. PORTES, Cook County: Who will act as secretary at Council meetings?

DR. MONTGOMERY: They elect their own secretary. (Motion carried.)

Chapter IX. Sections 1, 3, 4, 5, 6, 7, 8. Your committee recommends that action be deferred. The recommended changes abolish a constitutional committee without making provision for adequate substitute.

DR. SCHOWENGERDT: I recommend the adoption of this portion of the report. A resolution was sent from the House of Delegates to the Council requesting this. We have requested that they report to the House of Delegates what they have done. We recommend that the committee be left as it is until the Council reports on what they have done in May. (Motion seconded and carried.)

Chapter X, Section 1. Your committee recommends approval with the addition of the change of the word "speaker" to "presiding officer."

DR. SCHOWENGERDT: I move the adoption of this portion of the report. (Motion seconded and carried.)

Chapter XI, Section 8. Delete "and a list of non-affiliated registered physicians of the county." Delete "In making his annual report he shall account for every physician who has lived in the county during the year." Section 9. Delete "and a list of non-affiliated physicians of the county."

DR. SCHOWENGERDT: The committee recommends adoption of this portion of the report, and I so move. (Motion seconded and carried.)

Your reference committee further recommends that the Constitution and By-laws Committee consider clarifying the duties of the House of Delegates by including a statement such as: "The House of Delegates shall be the legislative body of the Illinois State Medical Society, and its deliberations shall bind the officers and the Council, and set the basic policy and philosophy of the Society," as the first section of Chapter V of the By-laws.

DR. SCHOWENGERDT: I move the adoption of this portion of the report. (Motion seconded and carried.)

Your committee further suggests that the constitution and by-laws of the Illinois State Medical Society be carefully reviewed by the Constitution and By-laws Committee, and such additions and corrections as are deemed advisable or necessary be made to bring it up to date.

DR. SCHOWENGERDT: I move the adoption of this portion of the report. (Motion seconded and carried.)

DR. SCHOWENGERDT: I move the adoption of the report as a whole. (Motion seconded.)

PRESIDENT: Did you not receive a resolution from Kendall County?

DR. SAXON, Kendall County: This resolution was not presented to the Constitution and By-laws Committee. We thought that this resolution should be presented to the Reference Committee on the Report of the Ad Hoc Committee. It was my impression that you had assigned this resolution to that reference committee. It seems to me that this particular resolution has been put into oblivion. I would like to propose again the consideration of this resolution on the floor of the House at this time.

PRESIDENT: I will entertain such a motion.

DR. G. B. CALLAHAN: If I understood Section 4 of Chapter 7 correctly, the presiding officer shall be the one who shall appoint the reference committees.

DR. SCHOWENGERDT: The committee changed that.

DR. C. MALCOLM RICE, JR., Cook County: I voted on the question of Suggestions 1 and 2. I think this is an important suggestion, while it does not have to be taken in its entirety. It says, Add to Article II of the Constitution entitled "Purposes of the Society", a declaration that an objective of the state society is to serve and strengthen component county societies. In the second suggestion which was voted on it says, "Add to the same Article II that an objective of the Society is to improve medical care for the people of Illinois with the least financial burden on the individual." I would move that we reconsider this and merely substitute and strike out the last sentence, "with the last financial burden on the individual."

DR. SCHOWENGERDT: When we discussed that particular suggestion, we referred to a copy of

the constitution and by-laws which are in print, which states:

> The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Illinois, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standards of medical education. It is further the purpose of this Society to protect the public by education as to medical care.

The members of the committee and at least 70-80% of the men in attendance at the reference committee did not like reference to "least" or to "financial"; in other words, they did not like it because the immediate impression is you have been overcharging.

Dr. Rice: I move that this be stricken out.

President: The motion was passed that they disapprove that section entirely.

Dr. Rice: My suggestion for reconsideration is that this part is left in; it has reference to the county society.

Dr. Schowengerdt: Refer to the front page; look at the top where it says "Purposes of the Society," under Article II. About the eighth line down it says, "to study and improve medical care."

Dr. Rice: That clarifies this for me.

Dr. Norberg: What about these changes?

Dr. Schowengerdt: These changes are to be made provided you accept the new officers, presiding officer.

Dr. Norberg: Is that all they considered in the Constitution and By-laws Committee, the changes recommended by this committee?

Dr. Schowengerdt: Only those that were referred to us by the president, pages 6, 10, 29, 43.

Dr. Norberg: Do you mean that the rest of the constitution which was last amended in 1903 remains the same?

Dr. Montgomery: These are the only recommendations that apply to the Edlund report. The attorneys for the Illinois State Medical Society have under consideration and study all the constitution and by-laws. Our Committee on Constitution and By-laws have many more minor changes which are to be recommended to the House of Delegates in May. This refers only to what this meeting was called for, consideration of the Edlund report. Also, the Constitution and By-laws were last amended in 1959, not in 1903.

Dr. Norberg: There are a lot of points in the survey that were glossed over and never brought up.

President: You are not sticking to the question.

Dr. H. Mantz, Madison County: I think the House is wasting time. I move the previous question. (Motion seconded and carried.)

(The motion to adopt the report as a whole was carried.)

Dr. Schowengerdt: This report is signed by Drs. Waren W. Young, Karl Vehe, S. M. Goldberger, Joseph R. O'Donnell, and William H. Schowengerdt, chairman.

President: The chairman of the Council would like to make an announcement.

Dr. Montgomery: There was a resolution presented by Kendall County, which was lost in the shuffle. I thought it was referred to the Committee on Constitution and By-laws but was not pertinent to this called meeting. There was one part that was pertinent. If Dr. Saxon wishes to present this to the House without reference he may. I so move. (Motion seconded and carried.)

Dr. Saxon: It is important that we listen to it. I would like your indulgence to summarize the resolution, and I will read a brief summary.

1. In essence the Kendall County resolution represents the opinion of the Kendall County membership, not only on the Forand bill but on socialism in any form.

2. The Forand bill and other social medical legislation constitutes only a symptom of the disease we call socialism.

The cause of this disease is personal irresponsibility of those of our people who constantly seek subsidy. This irresponsible trend of people (who do not constitute the majority of our Americans) produces the inflation which encourages more irresponsibility and thereby creates inequities and more problems — economic and others.

3. In order to counteract Forand-like legislation we must attack the cause and not treat the disease symptomatically. The freedom-eroding solution of the Illinois State Medical Society to the Forand bill in proposing fixed fee medical care in conjunction with a voluntary insurance plan is purely an alternative but equally socialistic solution to which our County Medical Society cannot subscribe.

4. Labor's proposal in the Forand bill already has widespread sympathy and support and our alternative solution is ineffective.

5. If we were to openly object to the Forand bill, our labor opponents would not fail to grasp this opportunity to make it appear to the people of our country that our interests are purely selfish. We must not use such a plan.

6. The American Medical Association and the Illinois State Medical Society can no longer sit idly by and assume in policy that they can combat socialism only as it pertains to medicine and effectively treat disease. It would be much more effective to join the forces of other groups who oppose socialism, inflation, and irresponsibility created by labor policies.

7. If socialism, inflation, and irresponsibility threaten to burn down our house, let us not be fools and offer to burn it down ourselves to solve the problem. There is no need to scuttle the ships in our harbor because of a proposed enemy attack – better let us attack the enemy with all our forces.

8. With an A.M.A. membership of over 200,000 active practitioners, we are experts in health and represent an essential structure in the social welfare of our nation. As such we are in position to deliver a mighty blow to those who would capture or destroy our freedom of decision and individual liberty.

9. We would, in conclusion, support any organized group for political action sponsored by our American Medical Association and Illinois State Medical Society, who will directly oppose socialism in all its forms, including those of medicine.

10. If it is necessary to form a separate political action group of our membership outside of our medical organization, for heavens sake, gentlemen, let's do it now. Let our Society implement such a change.

11. Let us make the action of labor unions and other forceful socializing agencies seek retreat and stop the economic spiral of disaster. Let us make a sense of responsibility in people an important part of their need to enjoy the freedoms still available.

PRESIDENT: I thought the purpose of your society was to present a resolution. I think the House should like to hear the resolution.

DR. PORTES, Cook County: That was the motion, to hear the resolution.

PRESIDENT: Will you please read the resolution as you wish to have the House hear it, so it can be discussed.

DR. SAXON: I bow in respect to the chair. I will present the resolution.

(Reads resolution See Page 188, First Session.)

DR. DOLAN: I move the acceptance of this resolution.

PRESIDENT: It is the position of this chair that this resolution is not germane to the call of this meeting. The chair will bow to the will of the House. I will declare this motion out of order. As last night, the chair will be glad to have his decision reversed if you wish to consider it. Otherwise, it is the ruling of the chair that this is not germane to the called purpose of this meeting; it is too broad. If you wish to reverse the decision of the chair, I shall be glad to hear a motion.

DR. SAXON: Was this not taken care of yesterday in the two-thirds vote?

PRESIDENT: It was not. That was only for one particular thing.

DR. HARLAN ENGLISH, Vermilion County: I move that the chair be supported. (Motion seconded.)

DR. DOLAN: I believe the chair is not considering in making a statement that this is not pertinent to our meeting, that one of the called purposes of this meeting was to discuss the questionnaire.

DR. PORTES: I move the previous question.

PRESIDENT: Let us have an explanation. I think that portion of the resolution submitted by Kane County was introduced into this called meeting by reversal of the decision of the chair. The only other thing that can be introduced into this meeting is something pertinent to the called meeting or by again overruling the chair in his position. It is the opinion of the chair that this resolution is not germane to the called meeting. If you wish, you are perfectly free to discuss that phase of it.

DR. DOLAN: I believe this resolution bore very much on the questionnaire which was discussed. We were asked to decide whether the questionnaire was effective. In order to do that we were called upon to say whether there is something else that can be done. This bears on the questionnaire. I believe it is the business of the meeting to consider Dr. Saxon's resolution.

PRESIDENT: Those in favor of sustaining the position of the chair, say aye; contrary, no. The motion is carried and it is so ordered.

Is there other matter pertaining to the call of this meeting?

May I say to you, we have really seen democracy in action at this meeting of the House of Delegates, and that is a privilege. May I further

say to you that nothing acrimonious or otherwise in this discussion should be taken away from this meeting. Let us behave like a brotherhood and not like brothers.

The chair will entertain a motion for adjournment.

It was moved, seconded, and carried that we adjourn *sine die*.

The House adjourned *sine die* at 1:55 p.m.

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Keeping in the swim

Many of the major medical plans offered today are rather intriguing in their benefits to the public. Similarly, closed panel plans have appeal to a substantial segment of our population, and undoubtedly will continue to grow. Competition in itself is healthy and is the American concept of private enterprise. This should keep us alert and "on our toes." If we are lackadaisical or refuse to meet this challenge, we will become controlled. In this competition, the doctor-sponsored medical bureaus have the best opportunity to retain for our patients, free choice, less third party intervention.

Many of our firms, industries and unions, are expanding into multi-county and interstate operation. We must be able to offer uniform benefits if we are to succeed in even holding our business, let alone getting new business. We must forget local differences and work together in harmony. A bundle of sticks securely tied together is difficult to break.

The world about us is changing, as is medicine itself. New systems, customs, philosophies and methods are appearing. Medical economics are changing and we must be willing to accept and grow with these changes, as well as be pliable to the new demands without compromising our quality, personal service, or ideals.

In conclusion, I would like to quote from Thomas Jefferson who stated: "Laws and institutions must go hand in hand with the progress of the human mind, as that becomes more developed, more enlightened. As new discoveries are made, new truths discovered, and manners and opinions change, with the change of circumstances, institutions must advance also to keep pace with the times." *Bertrand T. Fitzmaurice M.D. Our Doctor Sponsored Prepaid Plans in Washington. Northwest Med. Dec. 1959.*



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BOOK REVIEWS



MASTER YOUR TENSIONS AND ENJOY LIVING AGAIN. George S. Stevenson, M.D. and Harry Milt. $4.95. Pp. 241. Englewood Cliffs, N.J., Prentice-Hall, Inc., 1959.

That we are living in a shook up age is new to no one, but how to manage or master the attendant tensions remains an unsolved task or even a mystery for all too many.

Dr. Stevenson, who is an international consultant in mental health, and Harry Milt, a writer and movie producer with interests in the same field, have collaborated in writing this book. They combine their talents and experiences in attempting to teach the reader to free himself from everyday tension and anxiety.

After defining our shook up age, they discuss the etiology of anxiety and formulate a plan to control this tension state or rid ourselves of it. Eight tension breaks are listed: 1. Talk it out; 2. Escape for a while; 3. Take one thing at a time; 4. Get rid of your anger; 5. Curb the superman urge; 6. Take a positive step forward; 7. Do something for somebody else; 8. Knock down the barbed wire fences.

Having discussed these eight methods, the authors tell how to avoid tension-building situations in home, at work, or in any of the daily person-to-person situations we are liable to meet.

Actually this volume is a do-it-yourself kit, but is written on a higher plane and for more serious consumption than the myriads of other similar works flooding bookstores and newstands. It is good reading and easy to comprehend and digest because it hits home so consistently. As such, it is directed to layman and professional persons alike. The book may not become a best seller; but it should be in the hands of, or on the library shelves of, those who cannot master their tensions or enjoy everyday living.

Louis D. Boshes, M.D.

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CHEMISTRY OF PANCREATIC DISEASE. Harris Busch, M.D. $5.25. Pp. 160. Springfield, Ill., Charles C Thomas, 1959.

This biochemical discussion has presented in a monograph bits of knowledge concerning both exocrine and endocrine function of the pancreas. The combination is justified doubtless on an anatomic, but certainly not on a biochemical, basis. It is clearly written, well illustrated, and is evidently prepared for beginning medical students. The section on exocrine functions of the pancreas is excellent.

However, the section on endocrine function, especially that part concerning diabetes, is incomplete. References to basic investigations in the field are casual and outdated. Glaring omission of the Cahill and Thorn studies related to associated disturbances of lipid metabolism, and

(*Continued on page 72*)

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1. Hodges, F.T.: GP 14:86, Nov., 1956.

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BOOK REVIEWS (Continued)

the cursory presentation of the absorbing subject of insulin resistance illustrate superficial handling of the subject. Since "regular insulin" was removed from the market some years ago and all available insulin is crystalline, preservation of the term is unfortunate. Recommendations concerning emergency management of diabetes is dogmatic, incomplete, and inaccurate and would be challenged by many clinicians — as would many other of the clinical recommendations. With the exception of the endocrine section and clinical comments, this monograph should be useful to the medical student as a preface to basic study of the subject.

Ralph E. Dolkart, M.D.

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Appendectomy required

An advertisement inviting medical men to apply for places in an Australian government expedition to the Antarctic states, reasonably enough, that applicants must be in robust health. And then slips in a casual note saying that "appendectomy is essential before sailing."

Well, now, we've all become accustomed to being pricked, scratched, X-rayed, and even fingerprinted as a condition for permission to proceed to strange places; but it has taken the bold mind of a young and thriving nation to show us how pale and pusillanimous these measures have been. Of course, it would be awkward to have to do an appendectomy (or even an appendicectomy) in an igloo; and the difficulty would be sharpened in Antarctica by the absence of igloos. But it costs the taxpayer money if some incoming body has to be appendectomized in England — and, as for space ships . . . The obvious answer is for everyone to have the job done first wherever they are and before they go to wherever they hope to be. Let us older, stodgier people take the Australian hint, and frame forthwith a comprehensive list of health requirements to be fulfilled by all seeking license to tread our green and sanitary hills. As a fringe member of the health corps I would suggest as obviously desirable inclusions:

Prefontal lobotomy, to obviate the risk of having to treat some future anxiety state.

Splenectomy, thus reducing the chance of bleeding in motor accidents.

(*Continued on page 76*)



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Ideally, selection of the proper antibiotic for treatment of acute pharyngitis should await the laboratory reports on the susceptibility of the infecting bacteria. But the busy practitioner who sees many patients a day during the upper respiratory infection season may sometimes find it difficult to avoid the empirical choice of an antibiotic. Unfortunately, this practice may sometimes result in therapeutic failure.

No matter what the pressure of the immediate situation, it is worthwhile to consider taking a bacterial specimen from the infected pharynx for culture and sensitivity studies before starting treatment. Thus, a rational basis will be provided for changing the antibiotic should the first choice prove ineffective.

Which Antibiotic?

All other things being equal, the drug of choice is the one to which the pathogen is most susceptible. But if the exigencies of the situation force the physician to a prompt use of antibiotic, a broad-spectrum preparation that produces immediate high blood levels (e.g., tetracycline phosphate complex, TETREX) probably has the best chance of controlling the pathogen.

Later, the laboratory report frequently may indicate that any one of several antibiotic agents would be equally effective against the particular microorganism in question. In such a case other factors such as frequency and severity of side effects, sensitizing potential and toxicity should be considered.

If the acute pharyngitis in question should be due to gram-negative Klebsiella[1], penicillin will be of no value, nor will erythromycin be effective. However, this organism is susceptible to tetracycline. If the pathogen should turn out to be gram-positive Streptococcus or Staphylococcus, then penicillin, erythromycin, and tetracycline may all be effective against it.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reactions. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

The tetracyclines (e.g., TETREX) have the advantages of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

Some Microorganisms Susceptible[a] *to Tetracycline* (TETREX)[b]

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

[a] Some strains are not susceptible.

[b] Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics, 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

High blood, body fluid, and tissue levels of active drug are quickly attained when the new phosphate preparation of tetracycline (TETREX) is used.

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References: 1. Zinsser, H.: A Textbook of Bacteriology, 11th edition, New York, Appleton-Century-Crofts, 1957, p. 409. 2. Welch, H.; Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (December) 1957.

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APPENDECTOMY (Continued)

Gastrectomy, to safeguard the national stockpile of alkaline salts.

Pulmonectomy, to combat the rising incidence of bronchial carcinoma.

An astute minister for health soon will see that the system could be applied with advantage not only to odd incomers, but also to the natives. *In England Now. Lancet Oct. 10, 1959.*

The physician and politics

Only by such participation can the art of practical politics be elevated to the position of dignity that it deserves. By failing to become identified with political campaigns or to participate in partisan politics, a physician has more to lose than the few, if any friends or patients who might be alienated by such action. A far greater loss may be that of the private practice of medicine as an institution, the freedom of individual opportunity, and the high standards of medical care that he, as a physician, is dedicated to protect. *Editorial. The Physician and Practical Politics. New England J. Med. Nov. 19, 1959.*

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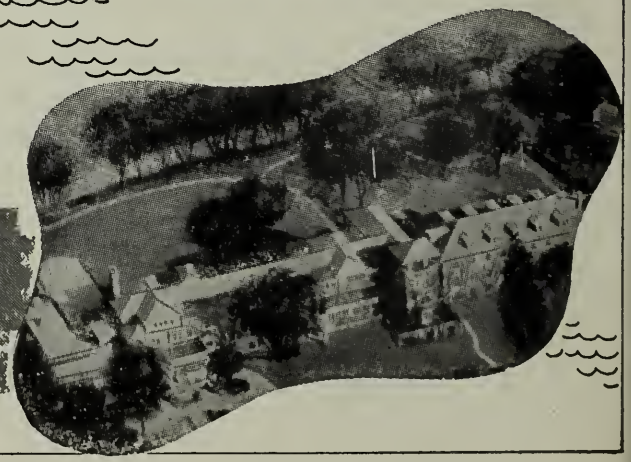
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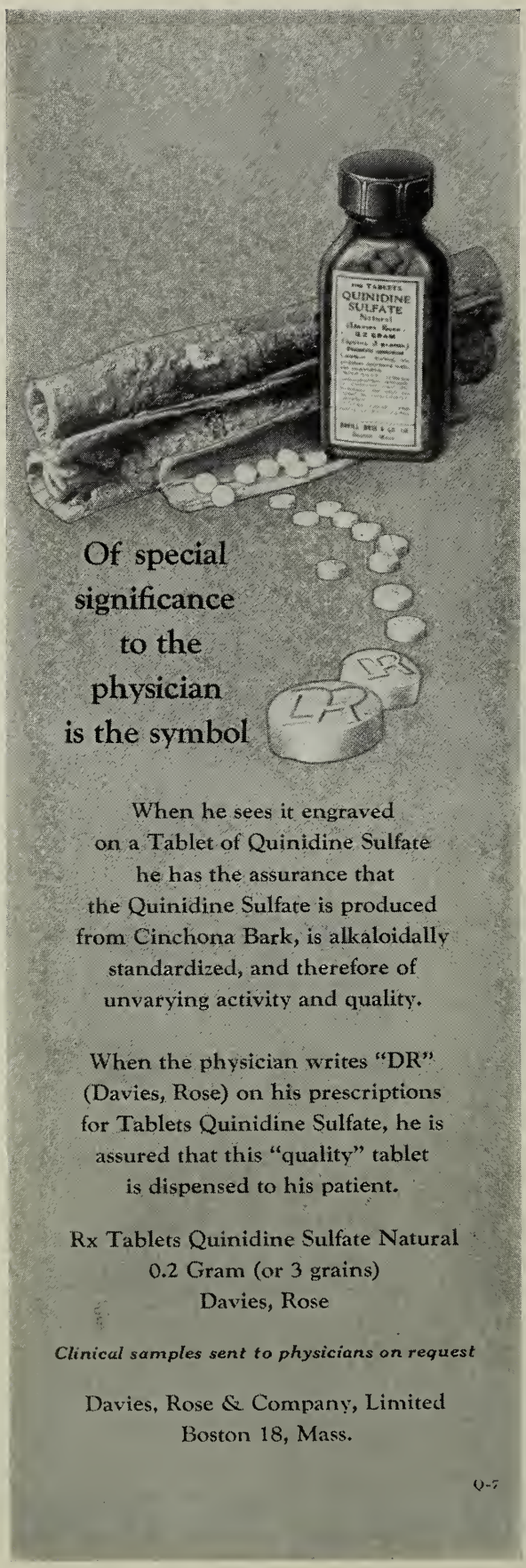
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How to manage the neurotic

To listen to a neurotic patient, one must begin to become aware of what one is listening for. The patient sitting in front of you is talking, gesturing, moving his arms, legs, and face. You may inadvertently hear stomach grumblings while he is talking. You may sense your own anxiousness without realizing at the moment where it is coming from. You may sense the patient's tone of voice changing, his interruptions, his omissions; his sequence may be confusing to you. You may sense an embarrassed smile come over his face and lips. He may appear restless. He may present pallor or flush of his face and neck. You may feel sleepy. You may sense that it may not be wise to call this to his attention at this time, or prefer to bring it up at another day when you feel he may be more amenable to your suggestive comment.

Just as you are sensing what is going on in your patient, so is the patient sensing what is going on in you. It is a two-way street. Knowledge of the patient alone is not paramount. The patient will sense the pseudoscientist in you with only a voyeuristic interest. This Freudian misconception (mostly of his followers) of the mirror kind of therapist has long been outdated as a result of recent advances in theory and technique. The neurotic patient usually resents this mode of listening and may react in various defensive ways to you. If you get caught in the patient's web and find it difficult to extricate yourself from this morass, you may find it necessary to refer the patient to someone who may be able to do a better job of it. *Joseph Zimmerman. M.D. The General Practitioner and His Neurotic Patient: The Art of Listening. Am. Practitioner Dec. 1959.*

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Vol. 117, No. 4

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The Month in Washington



Washington, D. C. — Congress has been warned against acting on legislation to provide health care of the aged before receiving the recommendations of next year's White House Conference on Aging.

Rep. Noah M. Mason (R., Ill.), ranking minority member of the House Ways and Means Committee which handles such legislation, put in the Congressional Record an exchange of correspondence with former Rep. Robert W. Kean (R., N. J.), chairman of the National Advisory Committee supervising preparations for the White House Conference next January.

Rep. Mason said the correspondence "reveals the reason why Congress should await the results of the Conference."

"Let us not waste the $2 million we have already appropriated to bring thousands of good minds together to suggest solutions to problems of our aging population," Rep. Mason said. "Certainly we should get the benefit of their advice rather than enact legislation in haste and without proper study."

Dr. F. J. L. Blasingame, executive vice president of the American Medical Association, also voiced this warning in a radio interview while he was in Washington for conferences with White House aides and Arthur S. Flemming, secretary of Health, Education and Welfare.

Dr. Blasingame said that it would be "neither practical nor realistic" for Congress to act on such legislation until the White House Conference and other sources had compiled "more conclusive and complete information" on a nationwide basis.

Dr. Blasingame and other AMA representatives emphasized to President Eisenhower's aides and Flemming that the medical profession is unalterably opposed to any legislation, such as the Forand Bill, that would use the Social Security system to provide health care for the aged.

In his letter to Mason, Kean predicted that "in all probability" most of the White House Conference's recommendations would be for "state and local activity" in dealing with the problems of the aged. Kean said that action at the state and local level "seems most effective."

The National Association of Manufacturers charged in a pamphlet that supporters of Forand-type legislation have exaggerated the health care needs of the nation's older people. The NAM pamphlet also said the Forand Bill was an entering wedge for a cradle-to-grave compulsory health insurance plan.

Meantime, supporters of the Forand Bill — particularly the AFL-CIO — continued an intensive pressure campaign aimed at Congressional approval of the legislation in this national election year when Congressmen are more susceptible to such pressure.

Another Democratic presidential hopeful, Sen. Hubert H. Humphrey (D., Minn.), reiterated his support for Forand-type legislation. He proposed a six-point program for aid for the elderly, including "an extension of the Social Security

(*Continued on page 26*)



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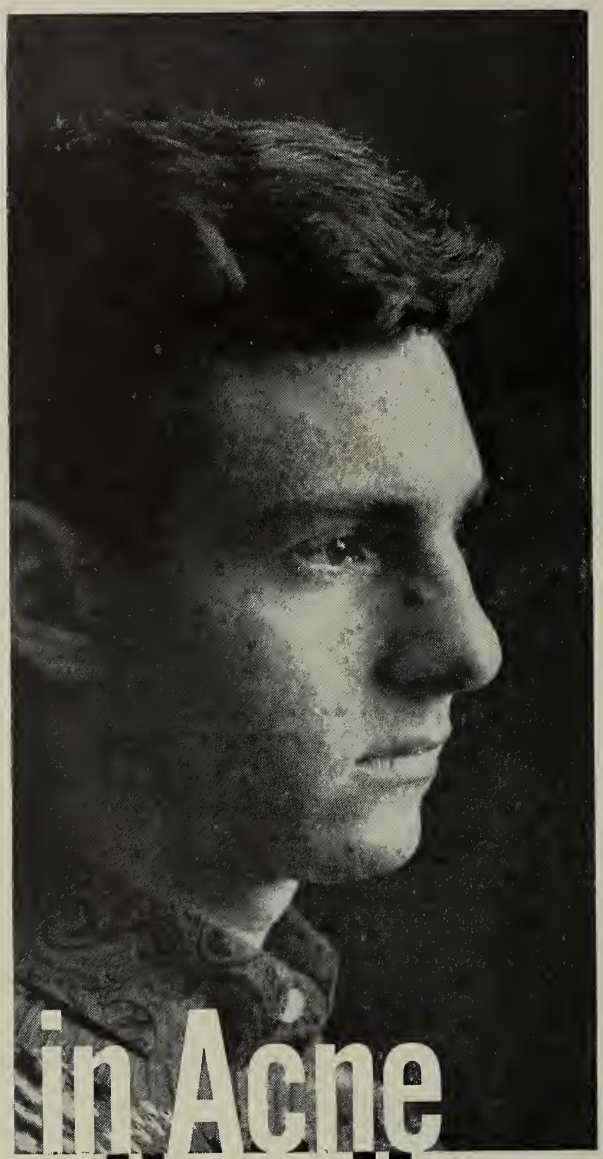
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1. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: *Brit. M. J.* 2:606, Oct. 3, 1959. 2. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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WASHINGTON (Continued)

system to cover the cost of hospital and nursing home care for senior citizens."

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, has introduced similar, but even broader, legislation.

Elsewhere on the national legislative front, prospects brightened for Congressional passage this year of a bill to permit physicians and other self-employed persons to set aside money for retirement.

The Administration, which last year opposed a bill with such provisions, appeared in mid-March to be ready to support it with modifications.

The Administration shift improved the already favorable odds that both the Senate Finance Committee, where a House-approved bill was pending, and the Senate would approve such legislation this session.

The issue of generic names vs. trade names in doctors' prescriptions came to the forefront in the Senate Monopoly Subcommittee's investigation of the drug industry.

Dr. Austin Smith, president of the Pharmaceutical Manufacturers Association, testified at a Subcommittee hearing that "behind brand names lie the reputation, reliability and skill of the manufacturer." He said use of generic terms would restrict a physician's choice as to drugs and would transfer some of the physician's responsibility to the pharmacist.

"By brand name prescription, the doctor orders for a patient a specific product in which he has absolute knowledge of quality, purity and any side effects that might have importance for a particular patient," Dr. Smith said.

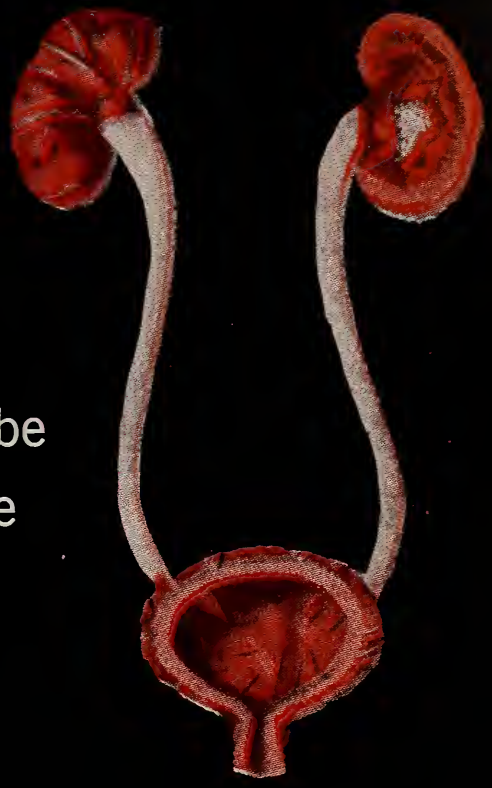
Dr. R. B. Robins of Camden, Ark., who accompanied Smith at the hearing, submitted a similar statement. He said he used trade names because, "It is simpler to write such a prescription and I can be assured that no substitution will be made by the druggist—this assures me that the patient will get top quality."

Dr. Robins appeared before the Subcommittee as a private practicing physician and not in his capacity as a member of the AMA Board of Trustees.

Despite this testimony, Sen. Estes Kefauver

(*Continued on page 37*)

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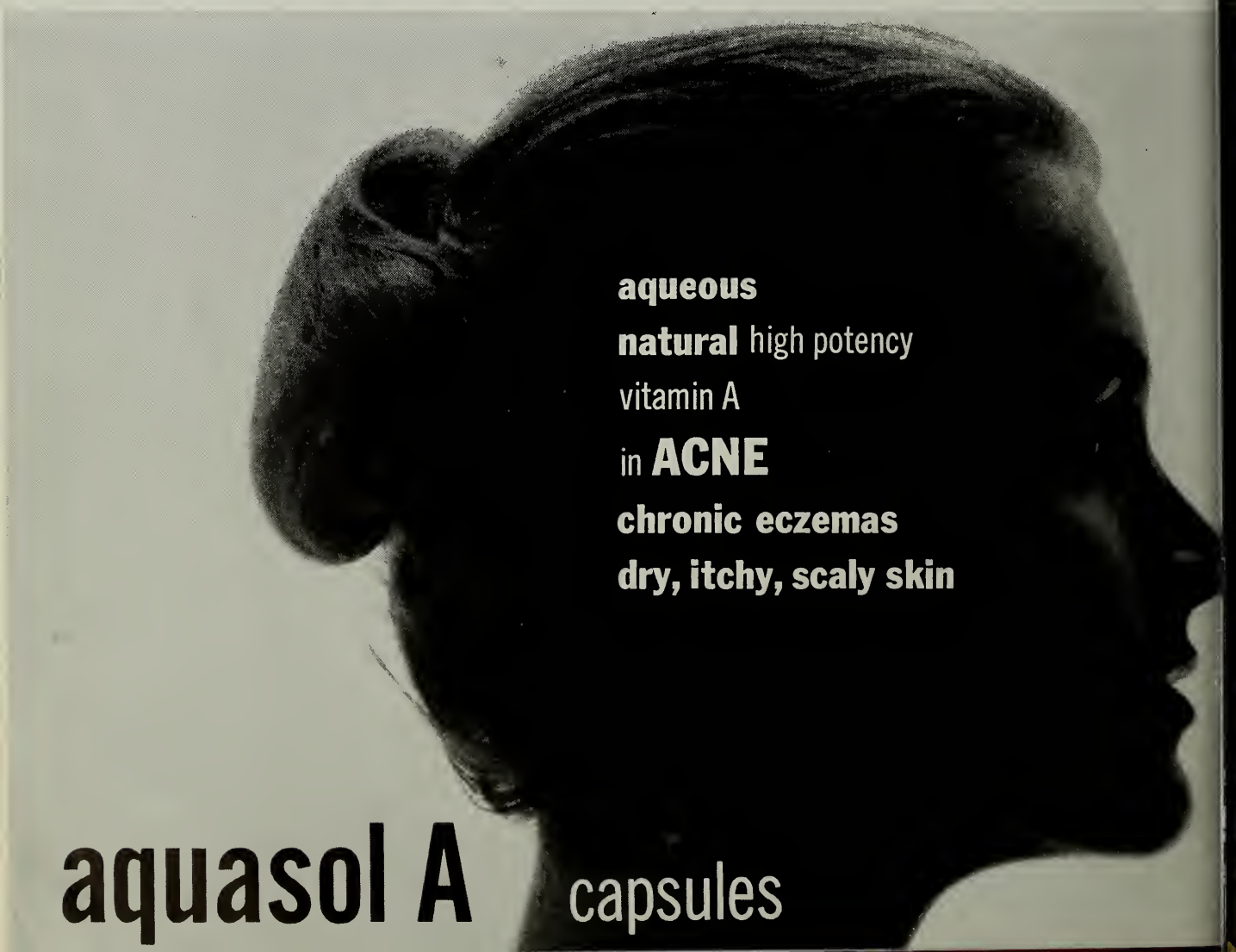
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WASHINGTON (Continued)

(D., Tenn.), the chairman of the Subcommittee, said he hoped physicians would give "serious thought" to use of generic terms. He contended that doctors thus could bring down drug prices by opening the way for small manufacturers to give the major companies "some good, honest, old-fashioned price competition."

President Eisenhower's Conference on Occupational Safety urged stronger x-ray legislation by the states with an aim of protecting consumers and workers against too much radiation.

The three-day Conference also said there is need "for effective educational programs to reduce both consumer and occupational exposures to x-rays used for diagnosis and therapy, x-ray installations in industry for product control and related purposes and various x-ray devices, such as shoe-fitting fluoroscopes."

The Conference also recommended intensive efforts to develop better ways of determining safe exposure levels of radiation.

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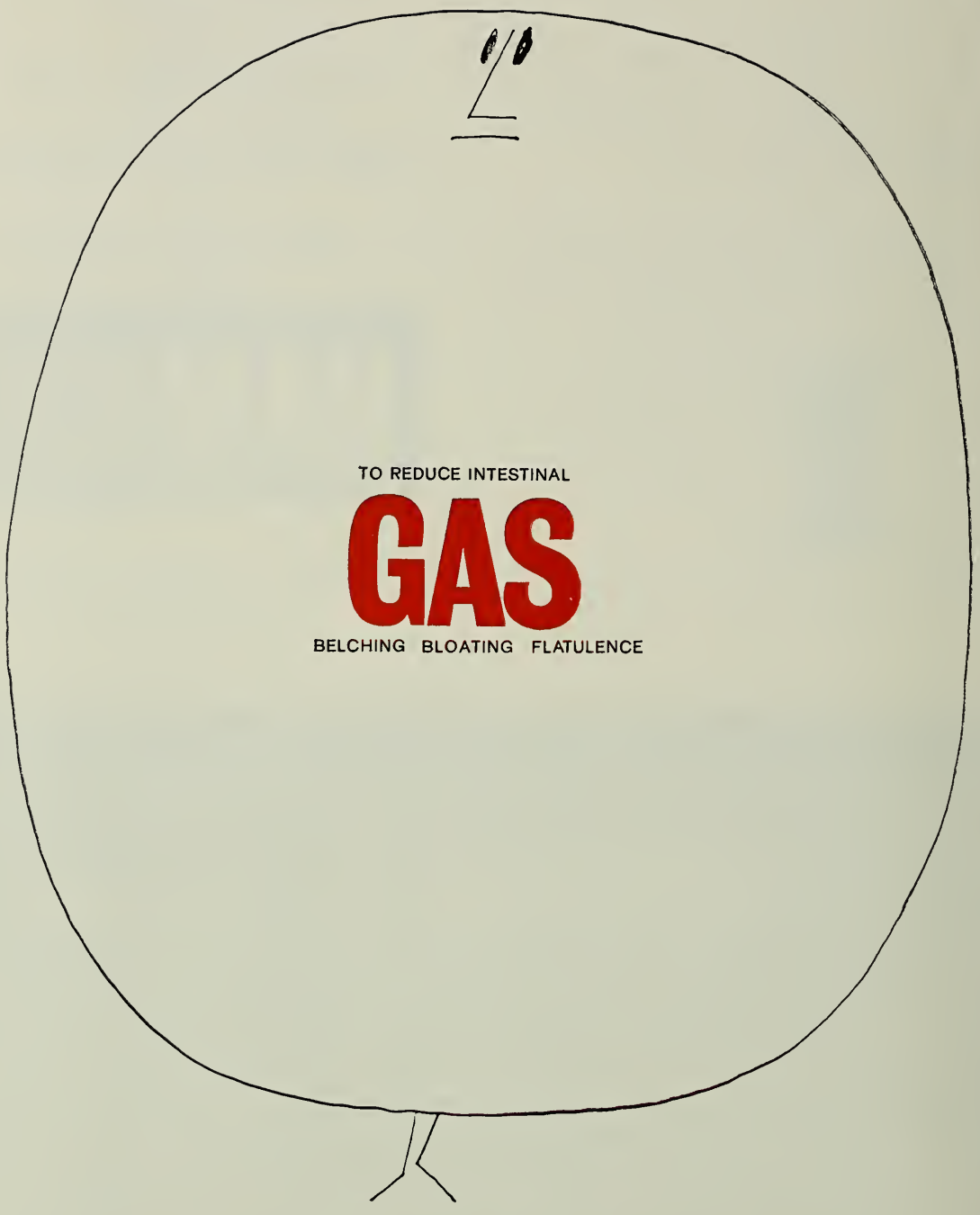
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The
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APRIL, 1960
VOL. 117, No. 4

The Surgical Management of Nonhypertensive Adrenal Disease

Joseph H. Kiefer, M.D. and James H. McDonald, M.D., *Chicago*

Until recent times, little surgery had been performed on the adrenal glands. Tumors that produce hypertension were removed occasionally, sometimes with success, but much too often with serious or even fatal consequences. Surgery for nonhypertensive adrenal tumors had equally serious complications and rarely was attempted. The surgeon could never be certain of the functional status of the opposite adrenal gland. Overactivity of the tumor tissue frequently led to functional depression or actual atrophy of the opposite adrenal gland. Removal of the tumor often produced a state of severe and sometimes fatal adrenal cortical insufficiency. This could not be controlled adequately with the adrenal cortical extracts available at that time. The discovery of cortisone and its derivatives has made it possible to prevent or correct these deficiency states and, by proper management, to do adrenal surgery with respectable morbidity and mortality rates.

From the Division of Urology, University of Illinois College of Medicine.

Given before the American College of Surgeons, April 6, 1959, Montreal, Quebec.

For purposes of clinical discussion we can divide the pathological conditions of the cortex into three main groups: 1. Disorders that lead to metabolic disturbances and are classed under the general heading of Cushing's syndrome; 2. Disorders that produce chiefly sexual changes classified under the heading of the adrenogenital syndrome; 3. Tumors that are neither metabolically nor sexually functional and that may arise either from the cortex or from the medulla.

By far the most important of the three groups is Cushing's syndrome. In 1932 Dr. Harvey Cushing described several cases presenting a peculiar syndrome that he attributed to basophilic adenoma of the anterior pituitary gland. A detailed discussion of the present theories of the etiology of Cushing's syndrome is not within the scope of this paper. It is believed to be associated with hyperactivity of the adrenal cortex; and the basophilic changes in the pituitary result from rather than cause adrenal changes.

Cushing's syndrome

Obvious on first observation is the marked obesity of the face and trunk with the extremi-

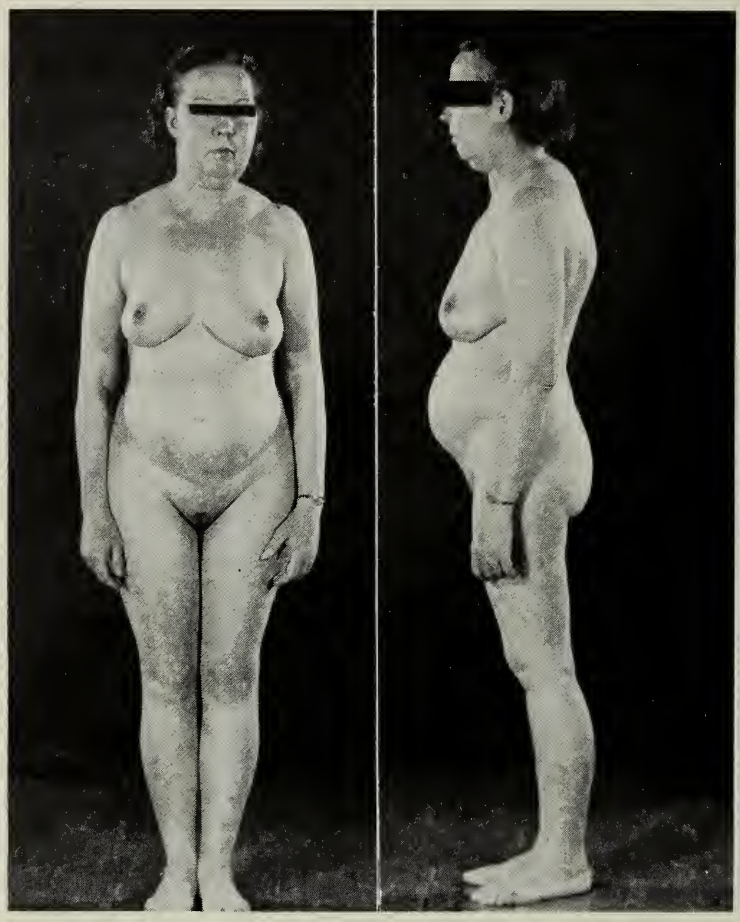


Figure 1. Cushing's syndrome. Patient G.G., preoperative photographs. Note the moon facies, nuchal fat pad, and the abdominal fat pad while the extremities are spared.

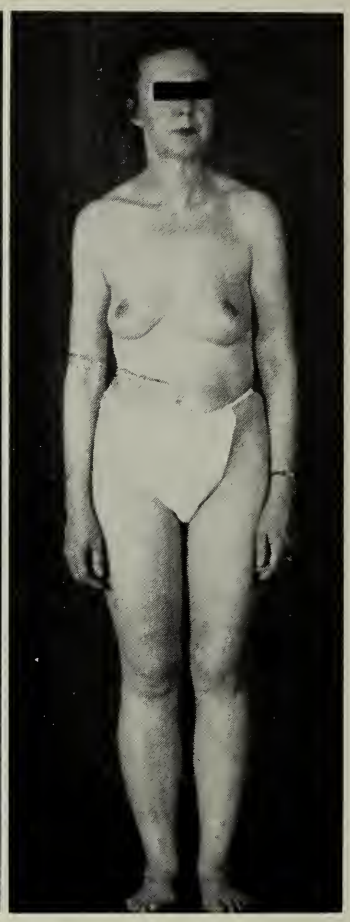


Figure 2. Patient G. G. 2 years following total bilateral adrenalectomy.

ties being spared. So-ealled abdominal apron, buffalo hump, and moon facies are characteristic. The skin, particularly of the face and trunk, becomes thinned and atrophic and develops a florid or violaceous appearance. Prominent purplish to silver striae develop over the breasts and abdomen. Aene appears especially on the face and back. Hair growth on the face, breasts, and trunk may be accelerated markedly. This hirsutism, as well as the other virilizing symptoms, vary in degree among the different patients. Scalp hair becomes thinner and may fall out. Ecchymoses into the skin are eommon, even slight trauma causing extensive bruises. Muscular weakness often is noted, accompanied by nervousness and tremor chiefly of the hands and extremities. Perspiration is inereased over the normal amount, and some of these patients eomplain of thirst. In female patients beyond the age of puberty, amenorrhea develops gradually with an assoeiated loss of libido.

Additional findings on physical and laboratory examination include hypertension which is common and, with the resultant cardiac ehanges, is one of the most serious aspects of the altered physiology. A diabetie state often is induced with oecasional glyeosuria but more frequently with an abnormal glucose toleranee curve. Changes in the electrolyte levels of the blood, when present, tend to increase the levels of sodium and earbonate. There is an increased excretion of the 17-ketosteroids and the 17-hydroxycorticosteriods. Osteoporosis is evident on skeletal X-ray.

Cushing's syndrome is a serious disease. Figures on the survival of patients who received no treatment show that approximately half were dead within five years of the onset of symptoms. Those who do not die are disabled by cardiovascular disease with hypertension, susceptibility to infection, and muscular weakness, as well as by the severe psychic alterations due to endocrine and physical ehanges.

Diagnosis sometimes is obvious at a single glance. The presence of the symptoms and findings enumerated above are sufficient to make the diagnosis. More difficult is the preoperative differentiation between tumor, either adenoma or carcinoma, and diffuse hyperplasia of the cortex. There is no way by which this may be determined from the findings so far mentioned.

However, tumor may be detected by X-ray studies. Displacement or deformity of the pyelograms, either excretory or retrograde, may disclose a tumor mass; retroperitoneal carbon dioxide insufflation and laminography usually aid in this study.

Recently, the use of the ACTH sensitivity test in these individuals has helped in the preoperative determination of the probable type of lesion. In bilateral diffuse hyperplasia, ACTH causes an exaggerated increase of the urinary 17-ketosteriods and an increase in both the plasma and urinary 17-hydroxycorticosteroids. In benign adenoma, the increase would be only that expected in normal individuals. In carcinoma there is no increase.

If the preoperative examination indicates tumor, the surgical approach would be made on the indicated side. However, the probable presence of a normal adrenal on the opposite side does not obviate the need for careful preoperative management. In the presence of tumor, the excessive hormonal output may lead to secondary atrophy of the opposite adrenal. Surgical removal of the tumor may be functionally equivalent to a total adrenalectomy temporarily. Therefore, the patient must be prepared as for a total and complete adrenalectomy.

In patients with adrenal cortical tumor, whether adenoma or carcinoma, replacement therapy usually can be reduced promptly and discontinued eventually. ACTH has been used as a stimulant to restore the functional capacity of the opposite adrenal in some of these cases. Where bilateral adrenalectomy has been done for hyperplasia, replacement therapy must be continued indefinitely and these patients will need additional replacement during periods of stress caused by infections, surgery, or injuries.

Adrenogenital syndrome

The innermost portion of the adrenal cortex, the zona reticularis, appears to be principally responsible for the production of the steroids associated with sexual development and the adrenogenital syndrome. This syndrome may be due to hyperplasia or to benign or malignant tumor. For the most part, the female is involved in the sexual alterations. Adrenocortical tumors producing feminization in males are extremely uncommon.

The clinical manifestations of this syndrome depend on the sex and on the age at which the lesion occurs. In female children there is precocious appearance of pubic and axillary hair. Associated with this, the clitoris becomes hypertrophied, the voice deepens, and there is marked hypertrophy of the skeletal muscles. There is rapid growth of the long bones due to a marked increase in the epiphyseal activity. This leads eventually to early closure and results in short stature unless the syndrome is interrupted. In the large majority of these cases the cause is congenital bilateral adrenal hyperplasia which, by its activity during fetal life and early infancy, leads to female pseudohermaphroditism. This condition is not uncommonly familial. Sometimes it is accompanied by deficiency of electrolyte controlling hormones which leads to a salt losing deficiency state that may go on to shock

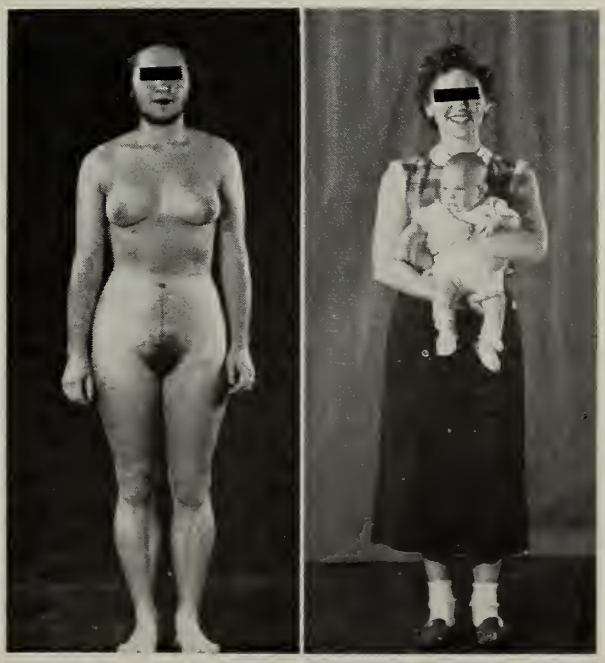


Figure 3. (Left) Adrenogenital syndrome. Patient A.B., preoperative photograph showing the marked hirsutism. (Right) Patient after removal of cortical adrenal tumor. Fertility is unusual.

and death if uncorrected. The urinary 17-ketosteroids are elevated above normal.

In the adult female, the adrenogenital syndrome causes excessive growth of hair over the back, chest, extremities, and face. There may be deepening of the voice, hypertrophy of the clitoris, atrophy of the breasts and the vaginal mucosa, and oligomenorrhea or amenorrhea as well as acne of the back, chest, and face. Some of these changes are minimal or may be entirely absent. The urinary 17-ketosteroids are always elevated in this syndrome.

The differential diagnosis in the adrenogenital syndrome must include precocious puberty, masculinizing tumor of the ovary, Stein-Leventhal syndrome, Cushing's syndrome, and constitutional hirsutism. In the presence of the clinical picture described, elevation of the urinary 17-ketosteroids strongly suggests either a virilizing adrenal tumor or a virilizing hyperplasia of the adrenals and normal levels tend to exclude adrenogenital syndrome.

The provocative cortisone test may be useful in distinguishing between adrenal hyperplasia and adrenal tumor. In hyperplasia there will be a suppression of the excretion of the urinary 17-ketosteroids. If tumor is present, the 17-ketosteroid excretion will be only slightly depressed but usually is unchanged or elevated.

Other important diagnostic studies include the use of excretory urography which may, in the presence of a sizable adrenal tumor, show depression or lateral displacement of the upper pole of the kidney on the involved side. Presacral insufflation of carbon dioxide gas, by visualizing the adrenal glands, may be extremely helpful in delineating a tumor mass. However, in most instances of adrenal hyperplasia, deviation from the normal is impossible to detect.

The adrenogenital syndrome in female children leads to an intersex state and sometimes difficulty in sex determination. Skin biopsy and oral mucosal smears to determine the chromatin pattern are helpful. Cystovaginoscopy will verify the presence of female internal genitalia. Exploration for this purpose is no longer necessary.

Treatment of the adrenogenital syndrome is entirely different in the two groups of cases. In the large percentage due to congential hyperplasia in infants and children, adrenal surgery is no longer done. Since cortisone administration was advocated by Wilkins in 1950, surgical treatment has been restricted to removal of the hypertrophied clitoris and plastic vulvar reconstruction.

In the smaller group where tumor is present, excision of the tumor is done. It is wise to treat the patient as discussed previously under Cushing's syndrome, both preoperatively, during the operative procedure, and postoperatively. We can never accurately assess preoperatively the degree of atrophy that may occur in the opposite adrenal gland. Therapy must be instituted to counteract any sudden collapse following removal of the tumor.

Clinically diagnosed nonfunctional adrenal tumors make up the smallest group. Both the cortical and medullary tumors mentioned previously are included. There are no symptoms due to functional derangements and these tumors make themselves known only by the effects of the increasing mass on the adjacent organs. In cases in which metastases occur there may be symptoms due to the metastatic lesions. Such tumors often displace the kidney and frequently are mistaken for tumors of renal origin. Pressure on the nearby bony structures may cause erosion with pain. Diagnosis is made or at least suspected on the basis of the changes in the excretory urogram, with confirmation by retroperitoneal carbon dioxide insufflation or retrograde urography. Treatment of these lesions is surgical excision. Occasionally roentgen therapy is used postoperatively if removal is incomplete and the tumor appears histologically to be roentgen sensitive.

Acute Renal Tubular Necrosis Complicating Salmonellosis

Graham A. Vance, M.D.* and W. R. Sunstrom, M.D.**, *Chicago*

It is well recognized that acute anuria, caused by renal tubular necrosis, accompanies such disease states as severe burns, crushing injuries, hemolytic transfusion reactions, eclampsia, hemorrhage, shock, and the ingestion or inhalation of nephrotoxic substances. Rarely is it emphasized that the severe loss of fluid and electrolytes accompanying gastroenteritis is capable of producing the same clinical picture. The recent occasion to care for a patient with acute anuria brought on by a severe enteric infection serves as the impetus for this report. In this instance the acute anuria was attributed to renal tubular anoxia resulting from diminished renal blood flow due to hemoconcentration.

On January 2, 1958, E.B., a 52 year old public utility employee, was admitted to our care. Three days prior to admission, and several hours after his noon meal, there was a sudden onset of diffuse abdominal cramping associated with violent vomiting. This was followed in several hours by urgency and the appearance of watery bowel movements numbering 15 to 20 the first day of the illness. Symptoms persisted for the remainder of that same day toward the end of which, he began to have chills, mild aching of some of the joints, and diaphoresis. While initially the stools were black, gradually they became green mixed with mucus. The above symptoms continued in decreasing magnitude for approximately 72 hours, during which time he was unable to take fluids or solids by mouth. He had no recollection of passing any urine since the onset of the illness, December 30, 1957. There was no history of contact with toxic agents nor were others in contact with the patient ill before or after the onset of his illness.

No history of gastrointestinal or urinary tract disease was obtained. Four months prior to the onset of the present illness, he was told at a blood donation center that he could not donate blood because he was anemic. A call to this center revealed that no records had been kept of their results of this man's previous hemoglobin determination. Following this refusal as a blood donor he saw a physician who put him on an oral preparation of iron and liver without additional blood studies.

Physical examination on admission to the hospital revealed the temperature to be 99° F.; respirations, 40/min.; blood pressure, 100/90; and pulse, 112/min. He was a small, well developed, middle-aged, white male whose skin was cool and clammy. The breath was foul and sordes was present. The eyes were sunken in the orbital fossae. There was distention of the abdomen, with moderate tenderness in all quadrants. Muscle fasciculations were observed frequently over the entire body. The remainder of the physical examination was not remarkable.

Initial laboratory studies

The initial laboratory studies revealed the following: RBC, 6,560,000; WBC, 9,600; hemoglobin 19.3 gm.%; blood urea nitrogen, 95.5 mg.%; chlorides, 77 mEq./L; carbon dioxide combining power, 18 mEq./L; and sodium, 126 mEq./L. The initial serum for a potassium determination was hemolyzed.

Parenteral fluids and electrolytes were begun shortly after admission in the form of 5 per cent glucose solution containing potassium, chloride, and sodium. The muscle fasciculations ceased late the day of admission. Fluids were administered in a volume thought to be necessary to correct hemoconcentration, and electrolytes in an amount approximating one-half the calculated deficit. A catheter was inserted into the bladder and 40 cc. of concentrated urine were obtained. It was acid in reaction, yielded a trace of albumin, 15-20 wbc/h.p.f., and a few hyaline and granular casts. Three and one half hours after fluids were begun, catheterization was done again and only 5

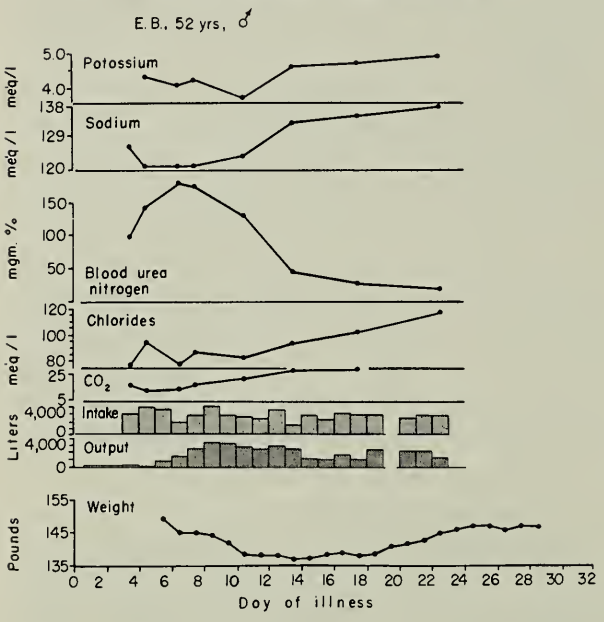
*Asst. Clin. Prof. Medicine, U. of Ill. College of Medicine and Associate Attending Physician, St. Francis Hospital, Evanston, and the Research and Education Hospital, University of Illinois, Chicago.

**Intern, St. Francis Hospital, Evanston.

cc. of urine were obtained. This indicated that we were dealing with true renal injury rather than dehydration with prerenal azotemia and acidosis.

Weight and fluid intake and output were measured daily. Throughout the early days, any need for fluid and electrolytes was based on the patient's daily weight and symptomatology, the serum electrolyte determinations being used only as a rough guide to therapy. The patient was observed several times daily for evidence of thirst,

Table 1.—Hospital Progress Chart



rales in the lungs, weakness, hypertension, and tachycardia. Thirst, nausea, vomiting, and frequent loose greenish stools were noted in the first eight hospital days. On January 3, the day after admission, the hematocrit was 43 and the this, daily fluid administration was determined by daily weight loss. We allowed administration of fluids in an amount that would permit an estimated daily loss of one pound in weight. In this manner, we were confident that overhydration could be avoided. On January 4, an indwelling catheter was put into place and left so as to determine output more accurately. In the next 24 hour period, 700 cc. of urine were excreted. 300,000 units of penicillin and 0.5 gm. of streptomycin were begun q. 12 h. The same day stool cultures were reported as positive for Salmonella organisms that later were identified as Salmonella typhimurium. That day, the hemoglobin was 13.4 gm.%, the hematocrit was 43, and the WBC was 6,900. The serum phosphorus was 7.4 mg.% and the calcium was 8 mg.%. Chloramphenicol was begun in the intravenous solution 0.5 gm. every 12 hours. Streptomycin was discontinued and penicillin reduced to 400,000 units daily. On 1/5/58 the dosage of chloramphenicol was increased to 1 gm. every 12 hours. The patient was more lethargic and weak and demonstrated Kussmaul breathing. These symptoms improved coincident with the intravenous administration of 1,000 cc. 1/6 molar sodium lactate solution. During the next night he became incoherent and climbed out of the bed. It was at this time that uremia was at its height with a blood urea nitrogen of 175 mg.% and a CO_2 of 14 mEq./L. (Figure 1).

On 1/8/58 a few coarse rhonchi were heard on deep breathing. A portable x-ray of the chest was normal. On 1/9/58, the WBC was 20,350 with a differential count of 1 eosinophil, 6 stabs, 74 segmented cells, 14 lymphocytes, and 5 monocytes. The hematocrit was 45. On 1/11/58, the temperature rose to 101° F. No cause other than a urinary tract infection secondary to the catheter was found. A urine culture revealed A. aerogenes and E. coli. Penicillin was discontinued on 1/13/58. Urgency and burning on urination were complained of on 1/14/58 and the indwelling catheter was removed. Urinalysis revealed a specific gravity of 1.007; albumin, 1 plus; 15-20 wbc; an occasional granular cast; and many bacteria/h.p.f.

The temperature remained normal after this day. Stool cultures continued to yield S. typhimurium despite adequate dose of chloramphenicol. Because of the species of organisms grown from the urinary tract, and the apparent insensitiveness of this strain of Salmonella to chloramphenicol, tetracycline was begun on 1/18/59 in a dosage of 0.5 gm. every six hours. The sensitivity of this strain of Salmonella had been determined previously by the antibiotic disc method. These tests indicated that chloramphenicol, tetracycline, and oxytetracycline were all inhibitory. This lack of response to chloramphenicol is but another instance in which clinical response was contrary to what might have been anticipated in relying only on antibiotic disc sensitivity tests. On 1/18/58, the hemoglobin was 10.6 gm.%; the RBC was 3,460,000, and P.S.P. excretion was 24 per cent in one hour and 17 in

the second hour, for a total of 41 per cent. On 1/20/58 a repeated urine culture grew A. aerogenes, P. vulgaris, and B. hemolytic streptococcus.

Again, the laboratory reported each organism insensitive to all commonly used antibiotics by the disc sensitivity testing method. This did not seem possible. On 1/21/58 the urea clearance resulted in a maximum clearance of 441 cc. or 81.6 per cent and the standard clearance of 78.5 cc. or 104.4 per cent. The blood urea nitrogen was 19.6 at this time. Smith and others have pointed out that where the reabsorptive power of the tubule is lost, it acts as a passive tube draining glomerular filtrate to the outside.[12] As the concentration power decreases, the urea fraction reabsorbed diminishes so that the clearance tends to approach the rate of glomerular filtration. On 1/23/58, the urinalysis revealed a specific gravity of 1.009. There were 5-10 wbc, a rare hyaline cast, and many bacteria/h.p.f. The hematocrit on this day measured 35 with 3.76 million RBC, and a hemoglobin of 11.2. gm.%.

Because of the past history of anemia, additional studies were undertaken in an attempt to determine a cause. The basal metabolic rate was plus 8. The upper gastrointestinal series, barium enema, and sigmoidoscopy examination revealed no abnormalities. On 1/28/58 the hemoglobin was 10.3 gm. %. On 1/29/58 a Mosenthal concentration test revealed the maximum specific gravity to be 1.014. Tetracycline was discontinued on 1/29/58 after stool cultures became negative. By the Diagnex® blue method, there was presumptive evidence of achlorhydria. Sternal marrow aspiration was done on 1/21/58 and examination of the stained smear revealed a diffuse nonspecific hyperplasia more accentuated in the erythropoetic series and with some immaturity of the granulocytic series. As there was no conclusive evidence of the cause for a pre-existing anemia of specific etiology, he was returned to the referring physician and advised to take 120 mg. of ferrous iron chelate a day.

Subsequent examinations by his personal physician revealed a hemoglobin of 12.8 gm. % and a hematocrit of 38.5 on 4/5/58. On 5/14/58, the hemoglobin was 13 gm. % and the hematocrit, 41. On 11/22/58 the hemoglobin was 14.2 gm. %, the hematocrit, 44. In each of these instances the WBC and differential blood counts were normal. A voided urine specimen on 4/5/58 revealed an acid urine with a specific gravity of 1.015. There was no albumin and the microscopic examination revealed 6-8 WBC/h.p.f. B.U.N. was 13 on 11/5/58. On 4/11/59 x-rays of the urinary tract by intravenous urography were normal. In addition, urinalysis was reported as normal.

Follow-up examination

The patient was seen again by us for evaluation in May of 1959. On 5/19/59 maximum specific gravity after witholding of fluids for 16 hours was 1.027. This specimen contained 10-20 WBC with an occasional small clump/h.p.f. On 5/27/59 urinalysis was repeated and a two glass test was done. There was no difference in the sediment seen in each glass. There were 30-50 WBC/h.p.f. with occasional clumps, rare granular and WBC casts, and many bacteria. On this same day, a quantitative urine culture was done and a pure culture of A. aerogenes was obtained. There were 3 x 10^{11} colonies per cc. In view of this he was begun on Furadantin® 100 mg. q. 6 h. on 6/8/59. This was continued for two weeks. Urinalysis at the end of the first as well as the second week revealed 1-4 WBC/h.p.f. and no bacteria on direct examination. Whether this organism was introduced at the time of the catheter drainage during the acute stages of the illness in late 1957 or whether it antedated this illness is unknown. It is felt that in either event no evidence of renal insufficiency is now discernible though undoubtedly pyelonephritis exists.* The patient is being followed at monthly intervals. In the event further urinalyses and cultures indicate recurrent urinary tract infection, other antibiotic therapy is contemplated.

Discussion

In the last two decades, investigators have described the pathology,[1,2] the disturbed physiology,[3] and the treatment for acute renal failure.[4,5,6,7,8] It should be stressed that in acute renal shutdown, there occurs extracellular fluid volume increase as well as increased total body water. The water formed through the breakdown of tissue is greater than was previously thought to be the case. This added extracellular water dilutes the serum sodium and there probably is

* addendum: Subsequent to submission of this paper, urine culture on 8/12/59 revealed no growth at a 10^{-3} dilution.

not actual significant lowering of the sodium quantitatively, unless there has been known sodium loss. Remenchick and others found that the extracellular fluid invariably increased and the total body water increased in the majority of eight patients in acute anuria.[9]

Bluemle found in single metabolic studies of anuric patients that in each 24 hour period, 330 milliliters per square meter of body surface (approximately 550 milliliters in the average person) maintained a constant ratio of total body water to body solids.[10] Depending upon the previous state of hydration, this figure serves as a useful guide to the volume need for fluid replacement in the patient with acute renal shutdown. If the total measurable and insensible calculated fluid loss is made up each day in the anuric patient, it results in giving a greater amount of fluid than necessary by fluid volume equivalent to that formed by tissue breakdown.

On occasion it is necessary to determine whether a given patient is not voiding because of dehydration or due to acute renal shutdown. The presence or absence of anuria can be determined readily by inserting an indwelling catheter into the bladder and calculating the rate of urine flow in a 30-60 minute period. Following this base line, 1000 cc. of 5 per cent glucose in water can be given intravenously over a period of 60 minutes. If this does not bring forth a significant increase in urine flow as compared with the base line, the patient can be assumed to have acute anuria rather than a dehydration oliguria.

Outline of treatment

As others have pointed out, by far the majority of patients in acute anuria can be treated conservatively. In such cases, we have found it rational to proceed in the following manner:

1. The urinary tract is investigated for obstruction, unless a definite renal cause is known.

2. An indwelling catheter may be placed in the bladder for accurate measurement of output or the patient may be catheterized as necessary to lessen the likelihood of infection.

3. The patient is weighed daily and fluids are given in a volume to allow a daily weight loss approximating one pound. In the average anuric patient, after any initial fluid deficits have been made up, this daily amount will approximate 550 cc. plus any added amount of fluid loss from other sources.

4. It is desirable to give at least 100 gm. of glucose per day, so with smaller fluid volumes it will be necessary to increase the concentration of glucose in the solution to between 15 and 20 per cent; 40 per cent concentrations of glucose probably are better yet.

5. Nothing by mouth should be given while anuria nauseated or vomiting is present.

6. If any loss occurs from the gastrointestinal or urinary tract, this may be estimated and an equivalent amount given back as normal saline. The giving of additional sodium without demonstrated loss is to be avoided even though the serum sodium value is low. Merrill suggests that low sodium also may be due to the patient having had too much in the way of fluids in the early phase of acute renal shutdown, in addition to the fluid expansion of the extracellular space with the dilution effect on the sodium. Should too much sodium or fluids be given inadvertently in the early phases of renal shutdown, and should pulmonary edema ensue, this may be counteracted by the oral administration of magnesium sulfate to produce intestinal fluid loss. If the condition of the patient becomes critical, a phlebotomy may be done.

7. An increasing serum potassium is to be anticipated and counteracted by giving large doses of calcium, hypertonic glucose with insulin (1 unit of regular insulin per 2 gm. of glucose), and potassium free exchange resins. In a recent patient who was anuric due to severe postoperative hemorrhage, we were able to lower the serum potassium from 7.4 meq/L. to 5.6 meq/L. in 17 hours with 35 gm. of exchange resins and 500 cc. 40 per cent glucose in water with insulin given through an indwelling catheter. The tip of the catheter was placed in the superior vena cava so as to avoid the irritant effect of high concentrations of glucose solution in smaller veins. Kolff has kept an intracardiac catheter in place for 28 days, giving hypertonic glucose with insulin to which 50-100 mg. of heparin were added daily to prevent thrombus formation at the end of the catheter. Approximately the same number of calories is contained in 600 cc. of 40 per cent dextrose as in 600 cc. of intravenous fat emulsion. Though we have not yet had the opportunity to administer one-half volume in 40 per cent dextrose solution with insulin, and the other half volume in a fat emulsion intravenously each day in a patient with acute anuria, this

combination should serve to give an improved nitrogen sparing effect.

The preferred resin is S.K.F. special resin No. 648, the suggested dose of which is 50 gm. per 24 hour period. This is an ammonium carboxylate cation exchange resin that preferably is given in small doses orally in cold water for maximum potassium binding effect. If nausea and vomiting preclude this, a 10 per cent suspension may be given (250 cc.) as a high retention enema every 12 hours and retained for several hours.

The electrocardiogram is best for determining the effect of serum potassium alteration on the myocardium. High peaked T waves, low P waves, and widened QRS complexes are indicative of hyperkalemia. Early fatalities in anuria generally are due either to hyperkalemia or to pulmonary edema. In the diuretic phase, on the other hand, additional potassium must be given. This becomes especially important if therapeutic measures have kept the serum potassium in a lower range previously. If the electrocardiogram and the serum potassium determination suggest that the increasing potassium concentration cannot be controlled by conservative means, the patient should be treated by dialysis by artificial kidney or by peritoneal dialysis. Advancing uremia and acidosis may also necessitate dialysis.

Schloerb recently suggested the composition of fluids for peritoneal dialysis and described the manner in which fluid for dialysis can be prepared from stock solutions.[11] The composition of fluid for peritoneal dialysis is:

Bicarbonate radical	27 mEq./L.
Sodium	135 mEq./L.
Calcium	5 mEq./L.
Chloride	80 mEq./L.
Lactate	33 mEq./L.
Glucose	27.6 gr.
Tetracycline	100 mg.

Preparation of each liter from sterile stock solutions, in cubic centimeters:

5% glucose in 0.85% saline	516
M/6 sodium lactate	198
10% calcium gluconate	10
50% glucose	3.6
500 mg. tetracycline in 20 cc.	4
Sterile water q.s.ad. 970 cc.	238
7.5% sodium bicarbonate	30

Peritoneal dialysis is performed by allowing as much of the prepared fluid to run in as comfortably and rapidly as possible. Up to 4 liters warmed to body temperature generally can be tolerated in adults. A standard intravenous infusion set can be used to administer the fluid through a 14 gauge needle inserted through the left flank of the abdomen. After allowing the fluid to remain within the peritoneal cavity for one hour, paracentesis is performed and a sterile tube is inserted 12 inches into the abdomen and the trochar removed. When approximately the same amount has drained out that has previously been put in, another cycle is begun; these cycles are done repeatedly for 12 hours after which 100 mg. tetracycline are instilled into the peritoneal cavity and the catheter is removed. The procedure may be repeated as clinically indicated though the catheter must not be left in place longer than one day because of the risk of developing peritonitis. Sodium bicarbonate for dialysis should never be boiled. Oral intake is to be avoided during peritoneal dialysis.*

REFERENCES

1. Lucke, Baldwin: Lower Nephron Nephrosis, Mil. Surgeon **99**:371, 1946.
2. Oliver, J.; MacDowell, M.; and Tracy, A.: The Pathogenesis Of Acute Renal Failure Associated With Traumatic And Toxic Injury, J. Clin. Invest. **3**:1307, 1951.
3. Oliver, J.: Correlations Of Structure and Function. Mechanisms Of Recovery In Acute Tubular Necrosis, Am. J. Med. **15**:535, 1953.
4. Gaberman, P.; Atlas, D. H.; Kammerling, E. M.; Ehrlich, Lee; and Isaacs, J.: Renal Anoxia Syndrome; A Review And Report Of 22 Cases, Ann. Int. Med. **35**: 148, 1951.
5. Strauss, M. D., and Raiz, L. G.: Treatment Of Acute Renal Shutdown, A.M.A. Arch. Int. Med. **95**:846, 1955.
6. Meroney, W. H., and Herndon, R. F.: The Management Of Acute Renal Failure, J.A.M.A. **155**:877, 1954.
7. Merrill, J. P.: The Treatment Of Renal Failure. New York, Grune and Stratton, 1955.
8. Kolff, W. J.: Acute Renal Failure; Causes And Treatment, M. Clin. North America, **39**:1041 (July) 1955.
9. Remenchik, A.; Schlonberger, J. A.; and Dyniewicz, J.: Changes In Body Water Compartments During Course Of Acute Renal Insufficiency And Their Relation To Water And Electrolyte Excretion, Am. J. M. Sc. **235**:189, 1958.
10. Bluemle, L. W.; Potter, H. P.; and Elkington, J. R.: Changes In Body Water Composition In Acute Renal Failure, J. Clin. Invest. **35**:1094, 1956.
11. Schloerb, P. R.: Peritoneal Dialysis And Newer Methods Of Intestinal Profusion In Renal Failure, A.M.A. Arch. Int. Med. **102**:914, 1958.
12. Smith, H. W.: The Kidney, Structure, And Function In Health And Disease, New York, Oxford University Press, 1951.

*Maxwell, M. H. et al.: Peritoneal Dialysis: Technique and Applications, J.A.M.A. **170**:917 (June 20) 1959 reported after submission of this manuscript a new "closed system" method for peritoneal dialysis. They used solutions already commercially prepared introduced into the peritoneal cavity through a nylon catheter with multiple perforations. These solutions, by their technique, then are allowed to flow out via the same catheter and tubing into the original bottles. All solutions and apparatus are available from Cutter Laboratories, Berkeley, California and Don Baxter, Inc., Glendale, California.

Laboratory Diagnostic Methods in Thyroid Disorders of Childhood

Ralph H. Kunstadter, M.D., *Chicago*

Great strides have been made toward a better understanding of the pathologic physiology of the thyroid gland during the past five years. Research in biochemistry has elucidated changes that can be interpreted in terms of abnormal function. As a result, our knowledge of abnormal processes has increased immeasurably to the point where we are better able to interpret clinically the pathological thyroid states. The use of isotopes in medicine has opened the door to new diagnostic and therapeutic horizons; and their application to the thyroid stands out as one of the greatest achievements.

Before discussing some of the latest advances, I believe I should present a critical appraisal of diagnostic laboratory methods in thyroid disease as they apply to pediatrics.

The inability to apply the basal metabolic rate to infants and most young children, and the unreliability of this test for most children of all ages, restricts its use to older children, who may give a good performance.

In striving for better diagnostic tools to delineate hypo- and hyperthyroidism in children, a great deal of interest was shown and efforts expended during the late 1930s and early '40s. A correlation between thyroid function and protein breakdown, carbohydrate absorption and metabolism, cholesterol metabolism, and alkaline phosphatase blood levels received considerable attention. Poncher et al. and others showed the changes in creatine metabolism and urinary excretion of creatine influenced by the administration of desiccated thyroid in hypothyroid children.[1] Emphasis on blood cholesterol levels in hypothyroidism was advocated by Bronstein[2] and Wilkins[3], and Althausen[4], Maclagan[5], and Kunstadter[6] who demonstrated changes in galactose absorption and blood levels as related to thyroid function. They advocated this test because it demonstrated more rapid absorption than glucose, and because normally its presence in the blood is undetectible and thus does not conflict with or become influenced by blood glucose. Talbot and associates showed a lowering of blood alkaline phosphatase levels in hypothyroidism and advocated this test as a diagnostic aid in cretinism and juvenile hypothyroidism[7].

Although all of these tests may be of some value, none is specific for thyroid function.

The older tests

The creatine excretion test is based upon the premise that physiologic creatinuria, which may be absent or markedly diminished in the hypothyroidism of childhood, is restored to levels observed for normal children by treatment with thyroid. The normal physiologic excretion of creatine is approximately 11.7 mg. per kilogram of body weight per 24 hours.

Although serum cholesterol values may be significantly elevated in hypothyroidism, and low in hyperthyroidism, these findings are not consistently present and as single tests may be misleading. Certainly, the level of cholesterol does not reflect the severity of thyroid disturbance in either instance. Furthermore, it has been demonstrated repeatedly that the serum cholesterol rarely is elevated in hypothyroidism in the first 6 to 9 months of life. Thus, this test may be particularly misleading in this period when early diagnosis is of paramount importance.

Our experience with galactose tolerance corroborates Althausen's and Maclagan's observations that when galactose is given orally (40 grams, adult dose) absorption is diminished in hypothyroidism and markedly elevated in hyperthyroidism beyond normal control levels as reflected in repeated blood levels similar to the glucose tolerance test. The sum total expressed in milligrams per 100 ml. of samples taken at

Associate Professor of Pediatrics, Northwestern University Medical School; Attending Pediatrician, Michael Reese Hospital.

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one half, one, one and one-half, and two hours has been designated the galactose index. The upper limit of normal is approximately 160, the average normal about 68, and the standard deviation is 39.3. The galactose index approaches normal before the basal metabolism rate and the serum cholesterol in patients under treatment with thiourea derivatives, and therefore may be of value in gauging dosage during treatment. The universal acceptance of this test is hampered by the fact that technical difficulties may arise, particularly with small infants. Thus the test may not be practical, and even more important, the results may be influenced by liver disease and gastrointestinal disturbances.

Alkaline phosphatase is reduced below normal range in about 90 per cent of cretinous infants according to Talbot[7], and recently confirmed by Lowery and associates[8]. Other conditions that may lower the alkaline phosphatase, such as scurvy, arthritis, achondroplasia, severe anemia, certain tumors, and severe malnutrition, can be excluded on the basis of clinical observations. Thus, lowered alkaline phosphatase may be considered confirmatory evidence of cretinism.

In 1947, Mann and her associates opened the door for more specific diagnostic measures,[9] and subsequent advances have appeared rapidly. She was able to measure the iodine precipitated with serum proteins. For all practical purposes the chemical PBI served as a good indication of thyroid activity, and proved to be of particular value in the diagnosis of hypofunction of the thyroid gland in infants and children. However, since the PBI represents not only thyroxin but all other circulating iodinated compounds bound to protein, interpretation must be qualified under certain circumstances. The PBI may be influenced by exogenous iodide and in various types of thyroid dysfunction — namely, goitrous cretinism — the PBI may be normal or even elevated and thyroxin may be a small fraction of the PBI.

Newer tests

Recently, Durham et al. as well as Man and Bondy employed a butanol-extractable iodine method that determines iodine of thyroxin-like substances of the serum without that of tyrosines or of inorganic iodide.[10] It is not influenced by exogenous iodide. This appears to be a more accurate measurement of thyroid activity than the PBI, and may be used as a valuable guide to therapy. Of various clinical disorders, only undernutrition plays a role in decreasing the BEI.

If, however, there is a discrepancy between clinical findings, I^{131} uptake by the thyroid, and the iodine of the serum, further steps may be necessary to identify the nature of the serum iodine compound. This can be accomplished by paper chromatography of the I^{131} of the plasma.

This brings us to the determination of the I^{131} uptake by the thyroid and urinary excretion as an indication of thyroid activity. It is of value in the diagnosis of hypothyroidism when differentiation of athyreotic from thyreotic cretinism is difficult. Its chief drawbacks are in cases of congenital enzymatic goitrous cretinism, when the uptake by the thyroid may be normal or elevated as previously mentioned, and by virtue of the considerable overlapping in the borderline states. In hyperthyroidism, results are more uniformly reliable. Recently, we have established values for normal children in the various age groups and found that in general they approach those of normal adults, and are somewhat higher in newborn infants.[12] In hyper- and hypothyroidism the elevation and depression of uptake respectively parallel the results in adults with the exceptions previously mentioned. Other drawbacks to routine use of I^{131} uptake are that it is influenced by previous ingestion of foods, vitamins, and drugs containing iodine, and because there are possible dangers of undesirable irradiation effects particularly after repeated performances. Thus, the determination of the BEI is more valuable as a single diagnostic test of thyroid activity in most instances.

In instances of hyperthyroidism associated with a thyroid nodule, the use of a scientilocalizer following I^{131} uptake may be of value in determining graphically the extent and/or localization of hyperactivity with the possibility of differentiating diffuse toxic from nodular toxic goiter.

Recently, we have become interested in a test that may replace the I^{131} uptake by the thyroid and obviate the necessity of ingesting potentially dangerous radioactive material. Within the past two years, Hamolsky and associates have devised a method whereby red blood cells of the plasma take up L-triiodothyronine^{131} in vitro and appears to parallel the actual uptake of I^{131} by the

thyroid.[13] Blood may be drawn from the patient in office or home, and the test run in an equipped laboratory within two hours. We have just completed our studies in children and adult controls, and find that our results confirm those of Hamolsky in adults; furthermore, they parallel the standards we established for I^{131} uptake by the thyroid in children. An additional value of this test may be that — like the PBI and BEI — it may serve as a guide to therapy in both hypo- and hyperthyroid patients.

Just a few comments about the differentiation of primary from secondary (pituitary) hypothyroidism. Pickering and associates have demonstrated a satisfactory test for use in infants and children, utilizing anterior pituitary thyrotropic hormone.[14] Data are presented showing 24 hour thyroid uptake of I^{131} before and after 48 hour administration of thyrotropic hormone. From 5 to 15 mg. per kilogram of body weight are given every 12 hours for four doses. A marked rise in pituitary hypothyroidism is demonstrated, as contrasted with primary hypothyroidism and euthyroid state in children.

Summary and conclusions

A review and evaluation has been presented of older, current, and newer mthods in diagnosis of thyroid disorders in children. It is concluded that determination of the butanol-extractible iodine of the serum is the most valuable single diagnostic test and guide to therapy in hypo- and hyperthyroidism. The I^{131} uptake by the thyroid may give significant information particularly in the differentiation of athyreoic cretinism from cretinism in the presence of thyroid tissue. However, application of the test to newborn and young infants may be difficult technically. The use of the scintigram may be of value in differentiating diffuse from nodular toxic goiter. Chromatographic analysis of the I^{131} of the serum may be necessary to determine the composition of the protein bound iodine in some thyroid dysfunctions. A new method, consisting of determination of the I^{131} triiodothyronine uptake by the RBC in vitro, may prove to be a valuable laboratory adjunct in diagnosis of hypo- and hyperthyroidism as well as a guide to therapy, obviating the administration of radioactive iodine to the patient. Differentiation of primary from secondary hypothyroidism may be accomplished by determination of I^{131} uptake by the thyroid before and after the administration of thyrotropic hormone.

REFERENCES

1. Poncher, H. G.; Bronstein, I. P.; Woodward, Helen W.; and Ricewasser, Jeanette C.: Creatine Metabolism in Hypothyroid Infants and Children, Am. J. Dis. Child. 63:270-296, 1942.
2. Bronstein, I. P.: Studies in Cretinism and Hypothyroidism in Childhood: I. Blood Cholesterol, J.A.M.A. 100:1661 (May 27) 1933.
3. Wilkins, L.; Fleischmann, W.; and Block, W.: Hypothyroidism in Childhood: I. The Basal Metabolic Rate, Serum Cholesterol and Urinary Creatine Before Treatment, J. Clin. Endocrinol. 1:3, 1941.
4. Althausen, T. L.: Hormonal and Vitamin Factors in Intestinal Absorption, Gastroenterology, 12:467 (March) 1949.
5. Maclagan, N. F.: Galactose Tolerance in Jaundice and Hyperthyroidism, Proc. Roy. Soc. Med. 34:602-606 (July) 1941.
6. Kunstadter, Ralph H.: unpublished data.
7. Talbot, N. B.; Hoeffel, G.; Shwachman, H., and Touhy, E. L.: Serum Phosphatase as an Aid in the Diagnosis of Cretinism and Juvenile Hypothyroidism, Am. J. Dis. Child, 62:273, 1941.
8. Lowrey, G. H.; Aster, R. H.; Carr, E. A.; Ramon, G.; Beierwaltes, W. H., and Spafford, Norma R.: Early Diagnostic Criteria of Congenital Hypothyroidism, Am. J. Dis. Child., 96:140, 1958.
9. Man, E. B.; Culotta, C. S.; Siegfried, D. A.; and Stilson, C.: Serum Precipitable Iodines in Recognition of Cretinism and in Control of Thyroid Medication, J. Pediat. 31:154, 1947.
10. (a) Durham, J. R.; Cooke, R. E.; Lancaster, J. W.; and Man, E. B.: Serum Butanol-Extractable Iodine Values of Children Under 10 years of Age, Am. J. Dis. Child; 87:468-475, 1954. (b) Man, Evelyn and Bondy, P.K.: Clinical Significance of Serum Butenal-Extractable Iodine. J. Clin. Endocrinol. 17:1373-1382 (Nov.) 1957.
11. Kunstadter, Ralph H.; Kohlenbrenner, Robert M.; and Oliner, Leo: Thyroid Dysfunction in Goitrous Children. Radioiodine Studies and Plasma Chromatograph Analysis for Thyroid Hormone, Am. J. Dis. Child.; 94:682-690, 1957.
12. Oliner, L.; Kohlenbrenner, R. M.; Fields, T., and Kunstadter, R. H.: Thyroid Function Studies in Children: Normal Values for Thyroidal I^{131} Uptake and PBI^{131} Levels Up to the Age of 18, J. Clin. Endocrinol. 17:61-75 (Jan.) 1957.
13. Hamolsky, M. W.; Goledetz, A.; and Freedberg, A. S.: Further Studies on Use of in Vitro RBC Uptake of L-Triiodothyronine^{131} as a Diagnostic Test in Thyroid Function, J. Clin. Endocrinol. 19:103-116, Jan. 1959.
14. Pickering, D. E., and Miller, E. R.: Thyrotropic Hormone in Infants and Children. Differentiation Between Primary and Hypopituitary Hypothyroidism, Am. J. Dis. Child. 85: 135-140, 1953.

Some Metabolic Studies In Quadriplegia Following Spinal Cord Injury

Alex J. Arieff, M.D., Stanley W. Pyzik, M.D., Eli L. Tigay, M.D. and Joseph Bernsohn, Ph.D.,* *Chicago*

Because of a paucity of long-term follow-up metabolic studies on patients with spinal cord injury, we thought it would be of interest to report the following data on severe spinal cord injury with quadriplegia. Isolated studies on man and animals have been reported and the changes observed on the acute effects of spinal cord injuries. By contrast, our data have been accumulated largely on chronic patients rather than those in the acute phase.

Material

Routine studies of blood chemistries, hemograms, and serum-glutamic-oxalacetic transaminase (GO-T) were done. Sixty-eight patients were examined more than one time, yielding data from 126 examinations.

In the first group there were 23 examinations on 18 physiologically complete quadriplegic patients, followed from one to 90 days after injury; the median time was 24 days after injury. The median injury site was the 6th cervical vertebra.

In the second group there were 35 examinations on 12 physiologically complete quadriplegic patients, followed from 3½ to 58 months after injury; the median time was 11½ months after injury. The median site was the 6th cervical vertebra, as above.

In the third group there were 23 examinations on 16 physiologically incomplete quadriplegic patients, followed up to 90 days after injury; the median time was 50 days after injury. The median level was the 5th cervical vertebra.

In the fourth group there were 24 examinations on 13 physiologically incomplete quadriplegic patients, followed from four to 12 months after injury; the median time was 7 months after injury. The median level of injury was the 6th cervical vertebra.

In the fifth group there were 21 examinations on 9 physiologically incomplete quadriplegic patients, followed from 13 to 38 months after injury; the median time was 19 months after injury. The median level of injury was the 6th cervical vertebra.

Patients admitted for the treatment of uremia, pneumonia, or other acute serious illnesses were excluded from this study.

Discussion of Literature

O'Connell and Gardner,[1] in discussing metabolism in paraplegia, reviewed almost all of the chemical changes in metabolism. This is an important contribution with a few personal references. We have drawn freely from their article.

Deitrick, Whedon, and Shorr reported, in a study on healthy young men who were immobilized in plaster casts from the waist down, progressive nitrogen loss from the 5th to the 6th day which reached a peak in 10 to 12 days.[2] Wyse and Pattee corroborated these findings.[3a]

Howard reported that the posttraumatic destruction of protein in the body is due to the trauma and is not necessarily related to the neurologic deficit. The reasons he gave were 1) loss of nitrogen, which is due to the increase of the excretion of nitrogen in the urine, there being no more than the normal amount of nitrogen in the feces; 2) nitrogen products of catabolized protein appear in the urine in the same pattern as in health — i.e., mostly in the form

*From the Neurology Service, VA Hospital, Hines, Illinois, and the Department of Neurology and Psychiatry, Northwestern University Medical School, Chicago.

Table 1.—Blood Chemistries in Traumatic Cord Injury with Quadriplegia

	Normal	PC 1 - 90 days	PC 3.5 - 58 mo.	PI 1 - 90 days	PI 4 - 12 mo.	PI 13 - 38 mo.
R.B.C. 10^6	..... (4.5 - 5)	4.5 (3.7 - 5)	4.8 (3.6 - 5.7)	4.5 (3.7 - 5.8)	4.7 (3.8 - 5.7)	4.8 (3.6 - 5.3)
Hb. %	..... (14.0 - 15.5)	13.7 (11.1 - 15.0)	14.0 (10.0 - 15.5)	13.0 (11.0 - 16.0)	14.0 (11.0 - 16.0)	14.0 (10.5 - 16.0)
W.B.C. 10^3	..... (6.0 - 10.0)	9.0 (5.2 - 16.1)	7.5 (5.0 - 18.9)	9.0 (41. - 27.9)	7.5 (5.5 - 16.0)	7.7 (5.4 - 18.8)
Total Protein gm./100 ml	..... (6.3 - 8.1)	6.3 (5.5 - 7.8)	6.9 (6.0 - 9.0)	6.9 (5.2 - 7.3)	7.0 (6.2 - 8.3)	7.0 (5.8 - 8.0)
Albumin gm./100 ml.	..... (3.3 - 4.3)	4.0 (3.0 - 5.1)	4.4 (3.5 - 5.5)	4.4 (3.4 - 5.2)	4.7 (3.8 - 5.4)	4.7 (3.8 - 5.0)
Globulin gm./100 ml.	..... (3.0 - 3.8)	2.0 (1.7 - 3.3)	2.5 (1.7 - 3.6)	2.5 (1.7 - 3.0)	2.6 (2.1 - 3.2)	2.4 (2.0 - 3.0)
A/G	..... (1.5 - 3.0)	1.7 (0.9 - 2.2)	1.8 (1.2 - 2.7)	1.9 (1.3 - 2.7)	2.1 (1.6 - 2.8)	2.3 (1.9 - 2.9)
Blood Creatinine mg./100 ml.	..... (1.0 - 2.5)	1.1 (0.6 - 1.4)	1.2 (1.1 - 1.3)	1.2 (1.1 - 1.3)	1.5 (1.1 - 1.7)	1.2 (0.9 - 1.5)
Blood Calcium meq/1	..... (4.5 - 5.5)	5.4 (4.5 - 6.7)	5.6 (4.7 - 9.2)	5.1 (4.7 - 10.0)	5.6 (5.0 - 6.2)	5.4 (5.3 - 5.5)
Blood P mg./100 ml.	..... (2.5 - 4.5)	3.0 (1.9 - 4.0)	2.5 (1.7 - 3.9)	2.6 (1.9 - 4.4)	2.5 (2.1 - 3.0)	2.4 (1.9 - 2.5)
Blood Na meq/1	..... (136 - 145)	138 (125 - 215)	141 (128 - 147)	142 (126 - 149)	138 (129 - 144)	133 (130 - 142)
Blood K meq/1	..... (3.5 - 5.0)	4.4 (3.5 - 4.6)	4.3 (3.5 - 4.7)	4.4 (3.5 - 5.0)	4.4 (3.5 - 4.6)	4.6 (3.4 - 5.2)
Blood NPN meq/100 ml.	..... (25 - 35)	32 (25 - 39)	31 (27 - 37)	32 (28 - 40)	30 (29 - 38)	32 (23 - 38)
Blood Urea N. mg./100 ml.	..... (10 - 15)	13.6 (11 - 17.3)	12.5 (5 - 20.5)	11.2 (9.9 - 15.4)	12.9 (9.8 - 14.0)	9.9 (7.8 - 14.6)
Blood Glucose mg./100 ml.	..... (80 - 120)	106 (80 - 150)	102 (85 - 112)	104 (80 - 118)	104 (90 - 115)	94 (80 - 130)
Blood Chlorides meq/1	..... (97 - 15)	103 (92 - 148)	105 (90 - 107)	103 (92 - 108)	107 (95 - 115)	102 (97 - 107)
Alkaline Phosphatase Bodansky units	..... (1.6 - 4.5)	3.2 (2.1 - 4.0)	2.8 (2.5 - 3.1)	3.5 (2.2 - 5.8)	2.8 (2.2 - 5.7)	3.3 (2.8 - 3.5)

of urea; the excretion of creatine, however, is increased disproportionately to the other components; 3) febrile states do not produce this reaction; and 4) large quantities of protein administered orally or parenterally did not spare the body nitrogen at the height of a vigorous catabolic reaction.[4]

Cooper, Rynearson, MacCarty, and Power found that 16 adult males with spinal cord injuries excreted large amounts of nitrogen, up to 29 grams daily.[5]

Cooper and Hoen reviewed 300 spinal cord injury patients during a five year period and found similar changes. The urinary excretion measured amounts up to 30 grams of nitrogen per day, representing 186 grams of protein, two to four weeks after injury, causing a marked negative nitrogen balance up to 25 grams per day.[6]

Robinson also found serum protein changes following a spinal cord injury, including the cauda equina. First, there occurred a rapid fall in serum albumin concentration with increase in alpha globulin in the early days of post-injury, and a slower rise and fall in the gamma globulin concentration. Second, the rate of fall of albumin concentration suggested strongly that the changes start slowly after injury. Third, increased protein catabolism caused increased excretion of nitrogenous metabolites in urine. Fourth, as far as the A-G ratio is concerned, the serum protein was rarely normal. He found that blood transfusions changed serum protein efficaciously.[7]

Anderson et al. studied metabolic and electrolyte changes in dogs following cervical spinal cord and midbrain sections. They did not believe that the electrolyte and metabolic changes could be attributed to the immobilization of the animal, since in one dog in which the tendons of the extremities had been severed (equivalent to immobilization due to a cord transection) there were no changes in electrolyte and metabolic patterns.[8] The inference is, therefore, that cutting off the central nervous system connections with the periphery profoundly influences bodily metabolism.

Results in present study

In our results the most marked changes were observed in the protein fractions of the blood. (Table 1) The medians of the total protein of all groups are in the lower limits of the normal range. The median of the albumin fraction in the physiologically complete cases, followed from one to 90 days and from 3.5 to 58 months, and also in the physiologically incomplete cases followed from one to 90 days, are all in the upper limits of the normal range. The median of the physiologically incomplete cases, followed from four to 12 months, and from 13 to 38 months, is above the normal range. The data indicate low globulin fractions in all groups with medians below the normal range. In the physiologically incomplete cases no overlapping with the normal range is found in the serum albumin. Only meager data on the excretion of nitrogen are available during the acute stages. Our cases early after injury were fewer in number than those previously reported in the literature. Furthermore, the data of Cooper and Hoen were from cases hospitalized early after World War II,[6] while many of the cases we have followed are more recent in origin.

Some low values of blood creatinine were found in the physiologically complete lesions from one to 90 days. This lowered blood creatinine may be a reflection of reduced creatine metabolism in spinal cord injuries. (Pollock, et al.[9])

Blood NPN and blood urea nitrogen changes were minimal, with some tendency for the upper levels of the normal to be exceeded in the earlier stages after injury. Blood urea also failed to exhibit noticeable deviations, although long-term cases tended toward higher upper ranges than normals. The absence of marked abnormality in blood NPN and blood urea nitrogen may reflect the better treatment available to these patients from the start.

With respect to other phases of metabolism, Deitrick, Whedon and Shorr showed the urinary excretion of potassium, phosphate, sodium and sulfur increased proportionately to the amount present in the muscle and correlated with the amount of urinary calcium excreted.[2] The amount of calcium in the urine was doubled and in the feces was increased variably. Creatine tolerance decreased with corresponding decrease in the mass and strength of immobilized muscles. Freeman,[10] corroborated by Wyse and Pattee,[3-b] found that immobilization increased urinary calcium excretion even in normal people. Freeman found as high as 23 to 25 per cent of the patients

had urinary calculi during recumbency. He noticed no change in blood calcium, phosphorus, or phosphatase. With ambulation, calcium excretion tended to decrease as, did the incidence of urinary stones.

Wyse and Pattee felt that the major cause of death due to genitourinary tract diseases was most likely due to hypercalcinosis, high increase in stones, infection, and dehydration. They recommended that steps be taken to correct these defects.[3b]

In our results, the blood calcium level tended to be above the upper normal limits of the physiologically complete and incomplete lesions up to 90 days, and in the older physiologically complete cases. An intensive study was done by us (Bernsohn and Pyzik[11]) on patients with a high incidence of calcifying myositis and/or urinary stones, on the ionizable and nonionizable blood calcium. No abnormal values were found to correlate with this high incidence. Many of these patients represented older cases who were not ambulant at an early stage.

Both blood sodium and blood chlorides showed some deviations from normal. The former showed values from 125 to 215 meq/l in physiologically complete lesions one to 90 days after injury, and values from 126 to 149 meq/l in incomplete lesions 1 to 90 days subsequent to injury. The fact that these abnormalities were found early after injury would implicate some hemeostatic defect in sodium metabolism at this stage of the trauma. O'Connell and Gardner mention decrease in blood sodium, whereas our results indicate only extreme deviation in the range. Blood chlorides also exhibited a wide range with the most extreme group occurring in the physiologically complete group, one to 90 days after injury. Increases in the median were observed in physiologically complete lesions up to 58 months, and in physiologically incomplete lesions up to 12 months. A defect in the homeostasis also may be the explanation of these findings. These results are contrary to those reported by O'Connell and Gardner[1] who found a decrease in chlorides.

Cooper et al.[5] and Cooper and Hoen[6] reported, mainly by BSP tests, that changes indicate impaired liver function. Decreased metabolic rate also was mentioned.

Serum GO-T values also were obtained in 34 cases of quadriplegics and the results are shown in Table II with a statistical analysis of results. The patients had an average serum GO-T value of 9.0 units, as compared to 13.2 for the control group; the differences are not large but are statistically significant since analysis of these results showed that the probability of this difference being due to chance was less than one to

Table 2.—Serum GO-T Values in Quadriplegia

		serum GO-T units ± S.D.
Controls	(15)	13.2 ± 3.9
Quadriplegia	(34)	9.0 ± 1.7
	$t = 5.12$	
	$P < .01$	

100. While muscle is not as high in GO-T activity per unit weight as heart or liver, it may be the major source of the serum GO-T, if the total mass of this tissue is considered. In quadriplegics the reduced muscle mass may be a reflection of the diminution of serum GO-T in equilibrium with muscle GO-T. The serum GO-T range in the 34 cases was extremely narrow as reflected in the small standard deviation of 1.7 units.

Observation of red blood count, hemoglobin, blood phosphorous, blood potassium, fasting blood glucose, and alkaline phosphatase showed no abnormalities worthy of comment. Some aberrations were noted in the white cell count, where variations from 4,000 to 28,000/cu. mm. were obtained, although median figures for all groups fell in the normal range. Mild infections are prevalent in most patients with spinal cord injuries.

Controlling depression

One of the big problems already mentioned in the acute stage is the psychological factor of acute reactive mental depression which occurs in injury as intense as paraplegia. This we see often. Depression certainly does not help metabolism in general, causing loss of appetite and weight, in addition to the factors already mentioned. It is our observation that the earlier the patients are received on the spinal cord injury section the easier it is to control this acute phase. This results in less loss of weight and fewer defects in metabolism. (Boshes, et al.[12] and Pollock, et al.[13]) With early intensive treatment, including intensive physical therapy, adequate protein diet, and early ambulation, the patient's co-operation and morale improve.

Case Reports

In the following cases we verified the acute effects on nitrogen metabolism by showing that there is an increased excretion of total nitrogen and urea nitrogen.

Patient T.G. is a quadriplegic, fracture dislocation at C-6, injured 5-3-58, and treated by us three months after injury. There was no evidence of anemia and no change in the blood NPN, BUN, creatinine, or total protein. The total urinary nitrogen excretion in 24 hours varied from 15.6 to 19.9 grams on three separate occasions (intake 120 grams of protein); the urea varied from 24.5 to 31.0 grams; and the creatinine varied from 1.0 to 1.42 grams for 24 hours.

Patient S.A.M. is a quadriplegic, fracture dislocation at C-5, injured 3-20-58, and treated by us five months after injury. There was no evidence of anemia or disturbance in the NPN, BUN, or total protein. The total nitrogen urinary excretion in 24 hours was 12.9 grams, the urea 17.8 grams, and the creatinine 0.77 grams.

Patient G.G. is a quadriplegic, also a fracture dislocation at C-6, admitted and treated 15 days after injury. This, our earliest case, showed no anemia and no disturbance in the NPN, BUN, or protein. The total urinary nitrogen excretion in 24 hours was 13 grams, the urea 31.5 grams, and the creatinine 1.66 grams.

Patient A.K., a cauda equina injury, treated within 30 days after injury, showed no enemia, and normal NPN, BUN, and total protein. The total urinary nitrogen excretion in 24 hours varied from 16.3 to 20.8 grams and the urea from 32 to 37.8 grams, and the creatinine 1.36 to 1.63.

The last two cases, although in the acute stage, showed relatively good protein balance. With respect to protein metabolism, the diets given our patients on the spinal cord injury section was total 2800 calories and the averages were as follows: protein — 120 grams, carbohydrates — 235 grams, and fat — 145 grams. Thus, if the patients are in negative nitrogen balance, they should excrete more than 120 grams of protein which is approximately 20 grams of nitrogen in the urine.

Summary

Sixty-eight quadriplegic patients have been examined for various phases of blood chemistry and metabolism. Some degree of variation from the normal was found in the blood protein fractions, with lowered globulin values in all groups studied and alterations in A/G ratios, and also lowered serum glutamic oxalacetic and transaminase levels; but changes in red blood count, hemoglobin, blood calcium, fasting blood glucose, and alkaline phosphatase were insignificant as compared to normals. Some minor changes from the normal values were found in blood NPN and blood urea nitrogen, blood sodium, and blood chlorides, but these were not extreme. The white cell counts were increased, probably due to chronic infections.

Although the literature after World War II documented many severe metabolic disturbances, specifically in protein metabolism, electrolyte imbalance, and calcium disturbances, these were not apparent in this study; and only minor defects in homeostasis occurred in patients treated earlier and more intensively, including physical therapy, early ambulation, improved nutritional knowledge, and the prevention of infection and bedsores.

References

1. O'Connell, F. B., Jr. and Gardner, W. J.: Metabolism in Paraplegia, J.A.M.A. **153**:706-711, 1953.
2. Deitrick, J. E.; Whedon, G. D., and Shorr, C.: Effects of Immobilization in Various Metabolic and Physiologic Functions of Normal Man, Am. J. Med. **4**:3-36 (Jan.) 1948.
3. Wyse, D. M., and Pattee, C. J.: Metabolic Alterations of Immobilization, Injury and Paraplegia: Treat. Serv. Bull. Dept. Veterans Affairs, Ottawa, Canada (3-a) Part I — Protein Metabolism, Vol. 8, No. 2, (Feb.) 1953. (3-b) Part II — Calcium and Phosphours Metabolism, Vol. 8, No. 3 (Mar.) 1953.
4. Howard, J. E.: Protein Metabolism During Convalescence after Trauma, Arch. Surg. **50**:166-170 (Mar.) 1945.
5. Cooper, I. S.; Rynearson, E. H.; MacCarty, C. S., and Power, M. H.: Metabolic Consequences of Spinal Cord Injury, J. Clin. Endocrinol. **10**:858-870, 1950.
6. Cooper, I. S., and Hoen, T. I.: Metabolic Disorders in Paraplegia, Neurology, **2**:332-340, 1952.
7. Robinson, R.: Serum Protein Changes Following Spinal Cord Injury, Proc. R. Soc. M. **47**:1109-1113 (Dec.) 1954.
8. Anderson, E.; Knowlton, K.; Lacqueur, G. L.; Spence, W. T.; Rioch, D. McK., and Haymaker, H.: Metabolic and Electrolyte Changes in Dogs Following Transection of the Midbrain in Cervical Cord, Tr. Am. Neur. A., 1954, 138-139.
9. Pollock, L. J., et al.: Creatine Metabolism in Paralysis due to Various Causes, Especially Injuries to the Sipnal Cord, A.M.A. Arch. Neur. Psychiat, **71**:116-121 (Jan.) 1954.
10. Freeman, L. W.: Metabolism and Calcium in Patients with Spinal Cord Injuries, Ann. Surg. **129**:177-184 (Feb.) 1949.
11. Bernsohn, J., and Pyzik, S. W.: Personal communications.
12. Boshes, B.; Zivin, I., and Tigay, E. L.: Recent Methods of Management of Spinal Cord and Cauda Equina Injuries, Comparative Study of WW II and Korean Experiences, Neurology **4** (9) (Sept.) 1954.
13. Pollock, L. J., et al.: Management of Residuals of Injuries to Spinal Cord and Cauda Equina, J.A.M.A. **146**:1551-1562 (Aug. 25) 1951.

Peptic Ulceration in Infants and Children

†Joseph R. Christian, M.D., ‡John B. Condon, M.D. and

Felicisima Paz*, M.D., Chicago

Peptic ulceration, although relatively common among adults, until recently, has been rare in infants, and children.[1,2] Approximately 500 cases have been reported in the literature and the majority of diagnoses were made at the autopsy table rather than during life. Terminal solitary or multiple ulcerations of the gastric or duodenal mucosa, found in infants and children, have been considered secondary manifestations of more severe infectious processes, central nervous system pathology, or burns[3,4,5]; such ulcerations rarely are considered part of the clinical picture.

However, the symptom complex of abdominal pain, abdominal distention, vomiting, diarrhea and/or constipation must be considered as seriously in the pediatric age group as in adults.[6,7,8,9,10,11,12] In addition, nutritional disturbances, gastrointestinal bleeding, and other unexplained gastrointestinal upsets can be and commonly are caused by peptic ulceration.[13,14,15,16,17]

Incidence

During the past nine and one half years, 68 cases of peptic ulcer were diagnosed in 14,716 admissions to a general pediatric unit of a private hospital. Only patients with positive roentgenographic findings have been included.

TABLE 1. — Incidence According to Total Admissions

Year	Admissions to Pediatric Service	No. Peptic Ulcer Cases
1950	1743	2
1951	1558	1
1952	1492	1
1953	1542	7
1954	1545	9
1955	1507	10
1956	1517	4
1957	1559	10
1958	1472	15
1959	781 (Jan.-June)	9
Totals	14,716	68

The total yearly admissions since 1950 varied from 1,743 to 1,472 and were dependent upon seasonal fluctuations of various diseases. However, the incidence of peptic ulcer at the hospital became more prevelant only after 1953, when a special effort was made by the members of the pediatric department to evaluate vague abdominal complaints more carefully and by the x-ray department to search more diligently in each upper gastrointestinal series.

The peak incidence of the disease occurred in the 7-11 year old white male patients. There were 17 in this group. Seven non-white males and 13 white females were found in this age range. No ulcers were demonstrable in the non-white female.

From the Department of Pediatrics and Department of Surgery, Stritch School of Medicine of Loyola University and Mercy Hospital, Chicago, Illinois.

Professor, Department of Pediatrics, Stritch School of Medicine, Loyola University, and Senior Pediatrician, Department of Pediatrics, Mercy Hospital.

Associate Clinical Professor, Department of Surgery, Stritch School of Medicine of Loyola University, and Senior Surgeon Department of Surgery, Mercy Hospital.

Formerly Chief Resident, Mercy Hospital, Department of Pediatrics.

TABLE 2. — Incidence According to Sex and Age (White)

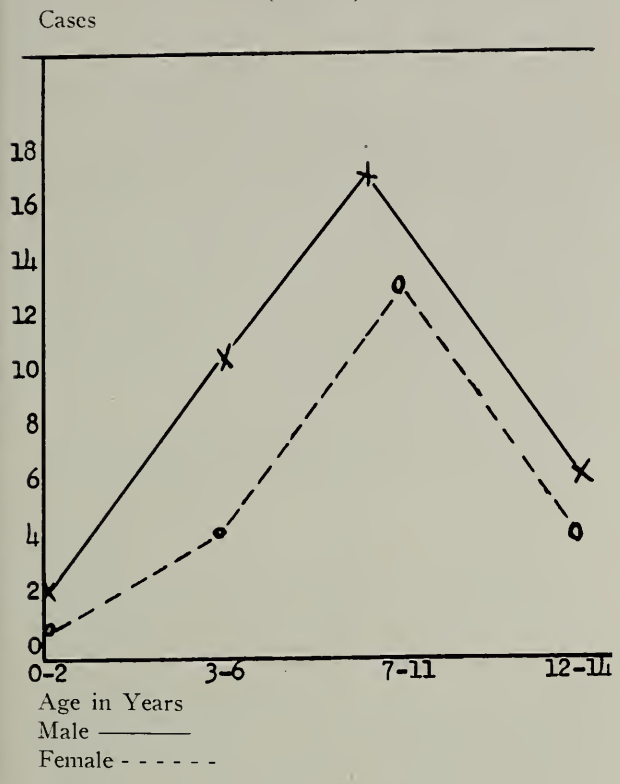
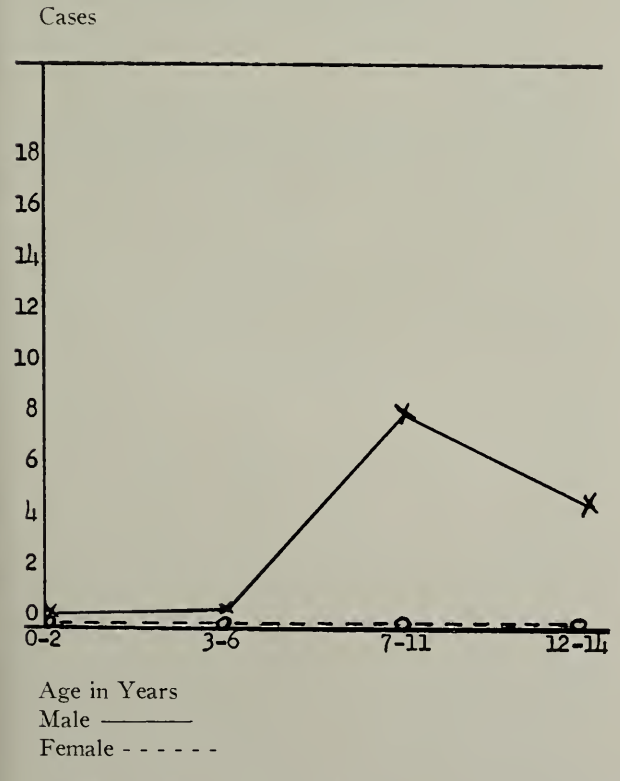


TABLE 3. — Incidence According to Sex and Age (Non-White)



Only one gastric ulcer was found in the entire series as an isolated lesion, and one patient had both gastric and duodenal ulcers. The age range of duodenal ulcers was as follows: 2 cases in the 0-2 year group; 14 cases in the 3-6 year group; 36 in the 7-11 year group; and 14 in the 12-14 year group.

TABLE 4. — Incidence According to Age and Location of Ulcer

Type of Lesion	AGE IN YEARS 0-2	3-6	7-11	12-14
Gastric	0	0	1	0
Duodenal	2	14	36	14
Others	1*	0	0	0

*Gastric and duodenal ulcers present in this patient.

Presenting Symptoms and Signs

The periodic dull, gnawing pain and/or burning sensation in the midepigastrium, that occurs in adults two to three hours after each meal or during the night and is relieved by food or alkali, is the exception rather than the rule in infants and children.

TABLE 5. — Presenting Symptoms

Symptoms	No. of Cases
I. Gastrointestinal:	
A. Abdominal pain:	
1. Mild	36
2. Moderate	4
3. Severe	5
4. Generalized	4
5. Localized	19
6. Intermittent	12
7. Persistent	2
8. Preprandial	6
9. Postprandial	3
10. Unrelated to food	4
11. Nocturnal	3
12. Diurnal	7
B. Nausea	11
C. Anorexia	5
II. Others:	
A. Headache	1
B. Precordial pain	1
C. Progressive weakness	3

As indicated in Table 5, pain was the presenting symptom in 45 of the 68 patients. In five, pain was severe; in four, moderate; in 36, mild. Only 19 complained of localized pain. Three of the 45 patients with pain as the presenting symptom were relieved by food intake and three complained of nocturnal pain. Twenty-

three failed to describe any type of abdominal pain.

Physical examination of the infant and child with peptic ulcer is as unrewarding as it is in the adult. Vomiting was the presenting sign in 17 patients; hematemesis, in two. Diarrhea was infrequent, occurring in four patients; constipation, in only one in our series. However, melena was found in 11 patients.

TABLE 6. — Presenting Signs

Signs	No. of Cases
I. Gastrointestinal:	
A. Vomiting	17
B. Hematemesis	2
C. Diarrhea	4
D. Constipation	1
E. Melena	11
F. Abdominal Rigidity	2
G. Abdominal Tenderness:	
1. Diffuse	5
2. Localized:	
a. Epigastric	8
b. Periumbilical	1
c. Others	6
II. Weight Loss	3
III. Personality Change	8
IV. Others	10

Abdominal tenderness and rigidity were infrequent, but localized tenderness was elicited in 15 cases at the time of initial examination.

A personality change easily recognizable by the parents and/or physician was demonstrable in only eight patients.

Coexisting Disease

TABLE 7. — Coexisting Disease

Disease	No. of Cases
Gastroenteritis*	3
Pneumonia with acute tracheobronchitis**	1
Rheumatic fever, inactive	3
Eczematoid lesion	1
Acute pharyngitis	1
Hepatitis	2
Epilepsy	1
Osgood-Schlatter's disease	1
Allergy	3
Total	16

*Duodenal Ulcer — complication of primary disease = 2 cases.

**Duodenal Ulcer — complication of primary disease = 1 case.

The possibility of peptic ulcer being a secondary manifestation of a primary disease of the central nervous system or gastrointestinal tract was considered by the authors. The paucity of this relationship is shown in Table 7.

In two cases of gastroenteritis, one a six week old white male and the other a 13 month old white female, duodenal ulceration with fatal massive intestinal hemorrhage was found. Also, one patient, a six month old white male with an acute tracheobronchitis, died of massive intestinal hemorrhage secondary to duodenal and gastric ulcers. Each of these patients had several factors in common:

1. All were infants under two years of age.
2. All were critically ill at the time of admission.
3. All infants received intravenous fluids, intravenous or intramuscular medications, and general supportive therapy indicated for the primary disease.
4. Adrenal cortical extract was administered for a clinical picture of adrenal exhaustion.
5. Each patient exsanguinated in spite of vigorous therapy to stop the hemorrhage, on the tenth day for the six month old, on the fifteenth day for the thirteen month old and on the thirteenth day for the six week old infant.

Complications

Hemorrhage was the only complication found in this series. Perforation and obstruction were nonexistent.

TABLE 8. — Complications

Complication	Age in Years			
	0-2	3-6	7-11	12-14
Hemorrhage:				
Mild	0	3	4	1
Moderate	0	0	0	1
Severe	0	0	0	1
Fatal	3	0	0	0
Perforation	0	0	0	0
Others	0	0	0	0

Hemorrhages occurring in patients under two years of age were all fatal (as previously described). Eight patients had mild hemorrhage, one moderate, and one severe. The severe hemorrhage occurred in a 14 year old Negro male. Surgical intervention was necessary and consisted of vagotomy and a posterior gastroenter-

ostomy. The patient was discharged from the hospital after an uneventful 10-day postoperative course.

Treatment and Results

Medical management consisted of an antacid (Amphojel®), a sedative (phenobarbital), and a bland diet in patients 7 years of age and over. In the 3-6 age group, treatment consisted of a bland diet and a sedative (phenobarbital). All patients with personality changes and their families received psychiatric help.

TABLE 9. — Treatment and Results

Result	Medical	Surgical
Improved	56	1
No Change	8	1
Died	3	0

On this regimen, 56 patients improved — that is, they were free of symptoms and showed x-ray evidence of a healed or healing ulcer. Eight patients showed no change — that is, their symptoms persisted and x-rays revealed no evidence of ulcer healing. Of three patients who died, two were undiagnosed until autopsy, and diagnosis of the third was confirmed by autopsy.

Discussion

A diagnosis of peptic ulcer in infants and children cannot be made unless the physician is aware of the existence and the incidence of this problem. The importance of roentgenologic survey of the upper gastrointestinal tract in all infants and children with undiagnosed vague abdominal symptoms and signs cannot be overemphasized. Other than laparotomy or autopsy, it is the only unequivocal diagnostic method available.

Characteristically, most children will indicate or complain of pain at the duodenal site during the fluoroscopic examination. Pylorospasm as well as a deformity and extreme irritability of the duodenal bulb are almost universally demonstrated. A crater with a radiolucent doughnut-type halo and radiating folds was the classical picture in each of our cases. Numerous spot films are essential in order to obtain a clear picture of the pathology. Many spot films of the crater are negative because a radiating fold obliterates the pathologic site.

Most of the older children—that is, those in the 7-11 and 12-14 age groups—obtained dramatic relief of symptoms following the ingestion of barium for the roentgenologic examination. This relief of symptoms persisted for several days. The only explanation we could offer for this phenomenon is that the barium relieved pylorospasm and duodenal irritability and coated the crater for a temporary period.

Gastric analysis and gastric acidity have little to offer in the diagnosis of peptic ulcer in childhood. Gastric acidity is at a peak during the first 24 hours after birth. This is followed by a gradual drop during the first 10 days postpartum and a slow rise to adult levels after 6 months of age.[7,18] Only infrequently does gastric acidity rise in the presence of peptic ulcer in infants and children.[19] The absence of standardization, the difficulties in technique,[16] and the minimal occurrence of hyperchlorhydria persuaded us to disregard this procedure as a diagnostic aid.

Tarry stools rarely if ever are seen in infants with bleeding peptic ulcer. In our series, bright red blood was found in the stool. The reaction of the gastrointestinal tract to blood appears to be directly proportional to the age of the patient —that is, bleeding in the infant produces extreme hyperperistalsis and in the older child, only a moderate increase of peristalsis. But, in either case, intestinal motility increases enough to produce bright red blood in the stool. Therefore, melena—especially if it is fresh blood—should suggest bleeding peptic ulcer as well as Meckel's diverticulum or intussusception.

The development of peptic ulcer in patients on long term steroid therapy has been documented.[20] The steroids increase hydrochloric acid and pepsin production, decrease the viscosity of the gastric contents, and inhibit fibroblast proliferation in wound healing and granulation tissue formation. In our series, the three infants who died of massive intestinal hemorrhage secondary to peptic ulcer had all received adrenal cortical extract over relatively long periods.

Emotional and environmental factors were seriously considered. An attempt was made to correlate parental occupation, tension in the home, sibling rivalry, the occurrence of ulcer in parents or siblings. There was no consistent correlation in any of these factors. One outstanding finding was the paucity of incidence among nonwhite patients. The emotional reaction of this group to

environmental factors appears to be far less than in the white group of similar status. No other explanation is apparent.

Treatment

The management of childhood peptic ulcer in our series consisted of varying degrees of the usual therapy. In the opinion of the authors, children under 7 do not need antacids or antispasmodics. Most of these ulcers are superficial in type with a minimal amount of pyloric or duodenal reaction. The diet usually is bland. Psychiatric assistance hastens recovery and prevents recurrences. If, as pointed out by a British author,[21] the ulcer personality is the effect rather than the cause of this disease, psychiatric management should be started as early as possible as a prophylactic measure.

Summary

An analysis of 68 cases of roentgenographically proved peptic ulcer seen in a private hospital over a nine and a half year period has been presented. There was a marked increase in the incidence among the general admissions to the pediatric unit after the interest of the clinician was aroused and a special effort was made to identify the disease.

The disease was relatively nonexistent in the Negro male and no ulcers were found in the Negro female. The highest rate of occurrence was found in the 7-11 year old white children, with the peak occurring in the white male.

Mild to moderate abdominal pain occurred in approximately 60 per cent of the patients. The pain was localized in approximately 28 per cent. Presenting signs were varied, with melena and vomiting noted most commonly.

Direct relationship to coexisting disease was not demonstrable. However, three fatalities occurred in the infant group due to massive intestinal hemorrhage secondary to peptic ulcer. Each of these infants had been treated with adrenal cortical extract.

Therapeutic considerations were discussed. Perforation and hemorrhage constitute the most serious complications in patients with peptic ulcer, although in our series hemorrhage was the only complication.

X-ray findings consist of pylorospasm, duodenal deformity and irritability, and an ulcer crater with a radiolucent halo and radiating folds. Gastrointestinal roentgenologic survey in all infants and children with undiagnosed vague abdominal signs and symptoms is the only unequivocal diagnostic method available. This must be done if the high mortality from the serious complications and the prolonged morbidity of the disease in older children is to be reduced.

REFERENCES

1. Proctor, D. S.: Chronic Peptic Ulcer in Children, Surg., Gynec. & Obst. 41:63, 1925.
2. Guthrie, K. J.: Peptic Ulcer in Infancy and Childhood with a Review of the Literature, Arch. Dis. Childhood 17:82, 1942.
3. Cole, A. R. C.: Gastric Ulcer of Pylorus Simulating Hypertrophic Pyloric Stenosis, Pediatrics 6:897, 1950.
4. Hollander, M. H., and Stark, M. W.: Duodenal Ulcer in Infancy with Presentation of Case, Pediatrics 6:676, 1950.
5. Curling, T. B.: On Acute Ulceration of the Duodenum in Case of Burn, Med-Chir, Trans. 25:260, 1842.
6. Jenkins, A.: Peptic Ulcer in Children, Texas J. Med. 48:767, 1952.
7. Tinder, R. B.: Peptic Ulcer in Infancy and Childhood, Minnesota Med. 33:57, 1950.
8. Alexander, F. K.: Duodenal Ulcer in Children; Illinois M. J., 102:5:285, 1952.
9. Donavan, E. J., and Santulli, V. T.: Gastric and Duodenal Ulcers in Infancy and in Childhood, Am. J. Dis. Child., 69:176, 1945.
10. Chappel, A. T., and Williams, J. F.: Duodenal Ulcers in Children, J. Indiana M. A. 49:942, 1956.
11. Girdany, B. R.: Peptic Ulcer in Childhood, Postgrad. Med., 13:249, 1953.
12. Girdany, B. R.: Peptic Ulcer in Childhood, Pediatrics, 12:56, 1953.
13. Moncrief, W. J., Jr.: Perforated Peptic Ulcer in the Newborn; Report of a Case with Massive Bleeding, Ann. Surg. 139:99, 1954.
14. Henrickson, W. E.: Gastroduodenal Ulcers in Childhood, GP. 10:64, 1954.
15. Bell, D. M.: Perforated Duodenal Ulcer in Children, Lancet, 2:810, 1954.
16. McAleese, J. J., and Sieber, W. K.: The Surgical Problem Presented by Peptic Ulcer of the Stomach and Duodenum in Infancy and Childhood, Ann. Surg. 137:334, 1953.
17. Bird, C. E., Limper, M. A., and Mayer, J. M.: Surgery in Peptic Ulceration of Stomach and Duodenum in Infants and Children, Ann. Surg. 114:526, 1941.
18. Miller, R. A.: Observations on the Gastric Acidity During the First Year of Life, Arch. Dis. Childhood 17:198, 1942.
19. Goldberg, H. M.: Duodenal Ulcers in Children. Brit. M. J. 1:1500, 1957.
20. Aagaard, P., Andreassen, M. Schidt, T.: Development of Peptic Ulcers During Treatment with Cortical Steroids; Acta. chir. scandinav. 116:423, 1958-59.
21. Kellock, T. D.: Childhood Factors in Duodenal Ulcer, Brit. M. J. 2:1117, 1951.

Our Aging Population and the Problem Of Chronic Illness In Chicago

HENRY L. SCHMITZ, M.D.** AND EDNA NICHOLSON***, *Chicago*

A LARGE proportion of chronically ill people are in the upper age brackets. For example, of the entire group of disabled people in Cook County, it is estimated that half are 65 years of age or older. If we consider only patients receiving long term care in institutional facilities, 67 per cent are over 64 years old, and 38 per cent are more than 75 years old. The higher percentage of aged receiving institutional care is due to the fact that older people are less likely to have families to care for them.

The problem created by chronic illness is tremendous. Statistics for the State of Illinois in 1956 show that 86 per cent of all deaths were the results of chronic diseases and injuries. This figure does not include the many individuals suffering from chronic diseases who finally succumb to pneumonia and appear in the mortality statistics under that heading. Influenza and pneumonia, the only acute diseases appearing among the first 10 causes of death, take more than one-half of their toll in the age group over 65.

During the period from 1940 to 1950 the number of people in need of long-term care in Cook County increased by approximately 20 per cent. It appears likely that there will be an increase at least as great as this for the decade from 1950 to 1960 despite the advances that have occurred in the prevention and control of chronic diseases and in the rehabilitation of the chronically disabled. The rapid increase in the population of the Chicago area, especially the increase in the number of older people, has more than offset the gains made as a result of improved methods of prevention, control, and rehabilitation.

It is estimated that in Cook County alone 750,000 persons are known to have chronic diseases, 60,000 of these physically impaired to the extent that protection and care must be provided for them; 40,000 are looked after in their own homes; and 20,000 are cared for in nursing homes, homes for the aged, or in other institutional facilities.

In the Chicago area alone, more than 1,000 organized agencies and institutions provide services for the chronically ill. The provision of these services occupies the full time of more than 25,000 paid employees. At least 5,000 more persons serve as board members and volunteer workers in the various agencies and institutions.

Present type of care

The Central Service for the Chronically Ill of the Institute of Medicine of Chicago estimates that current expenditures for these services in Cook County amount to well over $200 million annually and that this figure would have to be increased to at least $300 million to bring all of the services up to a fully desirable level. This figure does not include capital expenditures for construction and equipment of new plants and for remodeling of existing facilities.

The amount of care required by the 60,000 disabled people in Cook County varies tremendously. Approximately 30,000 of the 40,000 patients in their own homes are being cared for without help from organized community agencies, except in some instances, financial assistance is given in support of the household. In about half of the remaining cases cared for at home the only additional aid required is the

**Clinical Professor of Medicine, Stritch School of Medicine of Loyola University; President of The Central Service for the Chronically Ill of The Institute of Medicine of Chicago.*

***Executive Director, The Institute of Medicine of Chicago; Consulting Director, The Central Service for the Chronically Ill.*

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service of a visiting nurse. There are, however, at least 5,000 patients in their homes who need considerable care from organized community agencies, including nursing service, homemaker service, physical therapy, occupational therapy, social case work, special work projects to be done at home, and help in obtaining sick room supplies and equipment.

Of the 20,000 patients in need of care in nursing homes and similar facilities, about 1,480 need only minimal care consisting of board, room, laundry, housekeeping service, and general health supervision, with a responsible person on call and medical and nursing care available in case it should be needed. Another 6,800 require a considerable amount of personal attention and routine care of the type that can be given by aides, attendants, and matrons with general supervision by the physician and registered nurse. The remaining 11,720 are in need of regular nursing care.

Of the 20,000 patients in the Chicago area in need of institutional care, 5,700 are being cared for in privately owned nursing homes, 8,000 in voluntary philanthropic institutions, and 2,600 in institutions operated by government agencies; 1,700 are in general hospitals for want of acceptable places to go for long-term care; and about 2,000 are in hotels, boarding homes, and other places not operated or equipped for their care.

In 1955, in reporting the results of its statewide survey, the Illinois State Department of Health labeled as "unsuitable" 5,906 of the 6,848 nursing home beds in the Chicago area. Since that time, through the efforts of the Central Service for the Chronically Ill and others, there has been some improvement in the situation. Some of the unsuitable beds have been eliminated, some have been improved, and some new beds have been added. However, much of the long term care now being provided in nursing homes and related facilities in the Chicago area still is inadequate with respect both to the building safety and amount and quality of care.

The most immediate and pressing problem that we are facing in the Chicago area is the provision of more and better care for our chronically disabled people. To bring the institutional facilities for long-term care in Cook County to a desirable level, approximately 10,000 new beds are needed, and improvements must be made in many of the existing facilities. There is need also for expansion of present services in the community to help care for patients at home.

It should be emphasized, however, that these measures are not a solution to the problem of chronic illness. At best, they merely make life more tolerable for our chronically disabled people, which is important but is just one part of a highly complex situation. Unless we wish to be overwhelmed by increasing numbers of chronically ill and infirm people we shall have to do everything possible to prevent the diseases and accidents that cause disability and to provide prompt treatment, including rehabilitation, when they occur.

To accomplish these things we must have more research in the prevention and control of chronic diseases and more investigation of the social and emotional factors that contribute to invalidism and that influence the possibilities for rehabilitation.

We must place still greater emphasis on the problems of chronic illness in training our physicians, nurses, social workers, public health personnel, and hospital administration. We must increase the awareness of every individual in the community to his own health needs and to ways of meeting these needs effectively. Closely related to this is the necessity of eliminating the vast amount of misinformation in advertising, to the public, especially on radio and television.

We must provide more physical medicine and other rehabilitation services in our general hospitals. There must be more comprehensive and more effective planning for the transition from the patient's care in the hospital to subsequent care in his home or in institutional facilities. We must provide better correlation between social and vocational rehabilitation and the diagnosis, treatment, and physical rehabilitation of patients. It is essential that we expand our provisions for the prepayment of the costs of long-term care and that we provide more adequate payments for care of needy patients.

Above everything else there is need for better coordination of the work now being done. More than 1,000 agencies and institutions are providing services in this field. They are not all working together. There have been piece-meal planning in the development of new services and inadequate correlation in the planning and operation of facilities. Progress will be much more rapid if everyone works together.

Premarin Intravenous in Prostatic Surgery

C. K. Bobelis, M.D., *Elgin*

Excessive bleeding during and after prostatectomy is a problem that confronts every urologist repeatedly. True, the incidence of fatal hemorrhage is low, but excess blood loss in these old patients, already debilitated and disposed toward anemia, can complicate the postoperative course. For these and other obvious reasons, every effort is made to hold blood loss to a minimum, and any therapy reliably reported to be of value in this endeavor deserves consideration. The purpose of this article is to present the observations and results of a study on the use of Premarin® Intravenous before and after surgery on the prostate.

Outline of study

The series included 80 patients who underwent one of the four most commonly accepted prostatic operations: retropubic, suprapubic, perineal, or transurethral resection. The majority of the cases were observed prior to and after transurethral resections, since this type of operation is most commonly employed at our institution. In 18 patients a pathological diagnosis of carcinoma was made. The remaining 62 demonstrated benign prostatic hypertrophy.

The patients were divided into three groups:

1: Premarin Intravenous to control postoperative bleeding was evaluated in 30 patients.

2: Premarin Intravenous to prevent bleeding during and after surgery was evaluated in 30 patients.

3: Twenty patients served as controls.

Every attempt was made to observe all patients under identical conditions. All patients received essentially the same surgical technique therapy and pre- and postoperative (depending on the type of prostatectomy). Premarin was given by intravenous injection, using a 20 or 21 gauge needle. No other chemical hemostatic agents was used. In all three groups the average amount of prostatic tissue removed was 39 gm. The largest amount removed was 155 gm; the smallest, 12 gm. The amount of tissue removed did not appear to have a direct effect on the amount of blood lost.

Results

Observations of the efficacy of the therapy were based on the objective clinical findings, amount of blood loss during and after surgery, color of the urine postoperatively, hemoglobin determinations pre- and postoperatively, and the amount of blood used for transfusion during and after the prostatectomy. We did not evaluate bleeding, clotting, or prothrombin times. In reporting the results, each group will be discussed individually.

Group 1:

In these 30 patients, ages 44-98, the following surgery was performed:

Suprapubic prostatectomy	9
Retropubic prostatectomy	5
Perineal prostatectomy	2
Transurethral resection	14

The indication for administering Premarin Intravenous was an excess amount of bleeding postoperatively as determined by the color of the urine, blood clots, patient's condition, and the hemoglobin. An intravenous injection of 20 mg. was given on the first, second, or third postoperative day as indicated. No other hemostatic therapy was used. In 28 cases the urine was clear of blood (macroscopically) 24 hours after administering Premarin Intravenous. In two, it was necessary to give a second injection before the urine cleared and the excess bleeding was controlled.

Group 2:

The following type of surgery was done on these 30 patients, ages 45-91:

Suprapubic prostatectomy	8
Retropubic prostatectomy	4
Perineal prostatectomy	1
Transurethral resection	17

Premarin Intravenous was employed in this group as a prophylactic measure to reduce bleed-

Former Chief Resident, Department of Urology, Philadelphia General Hospital, Philadelphia.

ing during and after surgery. In 25 patients, 20 mg. were given by vein in the evening, 15 to 18 hours before the operation. In five, 20 mg. were given one to two hours before surgery.

In the open types of prostatectomies (suprapubic, retropubic, perineal) the amount of bleeding during surgery did not appear to be significantly reduced from that in Group 1 and the control group. However, in transurethral resection the results showed that intravenous Premarin serves a useful function as a hemostatic agent when given the evening before surgery. In these cases, bleeding during surgery was kept to a minimum, and the mechanics of operation were greatly facilitated. Not as much benefit was obtained in the five patients who received the injection one to two hours before surgery. In all this group, the postoperative period in relation to blood loss was more satisfactory than in the other two groups who had no preoperative medication. In the majority, the urine was clear of blood 24 hours after surgery, and the postoperative course was uneventful.

Group 3:

The following surgery was done on this group of 20 patients, ages 50-90, who served as controls:

Suprapubic prostatectomy	6
Retropubic prostatectomy	2
Transurethral resection	12

None of these patients received Premarin before or after surgery. Postoperative bleeding was more frequent than in the other groups. They were treated with the routine measures such as irrigation, traction with a Foley catheter, vitamin K, and blood transfusions as indicated. More blood transfusions were given in this control group than in either of the two treated groups. In the control group, 11 units of blood were given, compared to 10 in Group 1, who bled postoperatively and were treated with intravenous Premarin and only two in Group 2, who had been premedicated with Premarin Intravenous.

All patients tolerated the therapy well. No toxicity or side effects were encountered. Why the administration the evening before surgery is more beneficial than immediate preoperative use is difficult to explain because the studies of Johnson et al. indicate that the positive effect of Premarin Intravenous on the blood clotting mechanism is most active 30 minutes to three hours after injection.[1] Probably because Premarin is an estrogenic substance picked up and absorbed by the prostate as a result of which vascularity is reduced and the prostate gland constricts. Ende and Jacobson have reported excellent results using Premarin Intravenous to relieve acute urinary retention due to benign prostatic hypertrophy.[2] Jacobson reports minimal bleeding during prostatectomy when the patient is premedicated with Premarin Intravenous for several days prior to surgery.[3]

Summary and conclusions

A study is reported on the intravenous injection of Premarin as a hemostatic agent to reduce bleeding during and after surgery on the prostate and to control excess bleeding postoperatively. The 80 patients were divided into three groups: Group 1 received Premarin Intravenous postoperatively; Group 2, preoperatively; and Group 3 served as controls.

The results in Group 1 indicated that Premarin Intravenous is an effective, practical, and safe method of controlling excessive postoperative bleeding, the urine clearing in 24 hours after injection in 28 of the 30 cases.

The results in Group 2 indicate that the administration of Premarin Intravenous the evening before operation reduced bleeding to a minimum during surgery and facilitated the operative technique in transurethral resection. In open surgery on the prostate, the therapy did not seem to be of any benefit, and administration one to two hours preoperatively did not give as good results as administration 15 to 18 hours before surgery. The results also indicated that in all patients the preoperative use of Premarin Intravenous markedly reduced the amount of hemorrhage during the operation and postoperatively.

On the basis of these results, we believe that the administration of 20 mg. of Premarin Intravenous the evening before operation will in most cases help control excess bleeding associated with prostatic surgery, particularly in the transurethral resection.

434 Algona Avenue

REFERENCES

1. Johnson, J. F., and Seegers, W. H.: Changes in Plasma Prothrombin, Ac-globulin, and Antithrombin Concentration following Intravenous Administration of Estrogen, Proc. Soc. Exper. Biol. & Med. **94**:92 (Jan.) 1957.
2. Ende, M., and Jacobson, P.: Treatment of Benign Prostatic Hypertrophy with Estrogen Administered Intravenously, Report of 17 Cases, J. Am. Geriatrics Soc. **5**:676 (July) 1957.
3. Jacobson, Philip: Personal communication to the author.

Clinical-Surgical Conferences



Acute Neurosurgical Trauma

Cook County Hospital

Moderator: Robert J. Freeark, M.D.
Director of Surgical Education
Cook County Hospital

Discussant: Loyal Davis, M.D.
Professor and Chairman of Department of Surgery,
Northwestern University Medical School; Chief of Surgical Services, Passavant Memorial Hospital

Dr. Robert J. Freeark: Traumatic injuries of the nervous system include a wide range of disorders in which therapy is controversial and results difficult to evaluate. The more frequent craniocerebral injuries have received considerable attention in recent years in the teaching of trauma, but there remains a large segment of neurologic injury which is inclined to be overlooked in the training of a surgeon. I refer to injuries of the spinal cord and peripheral nerves. It is in this area particularly that the first doctor to examine and treat the patient is likely to be someone other than a neurosurgeon.

The neurologic injury is frequently accompanied by fracture, a penetrating wound of the chest and abdomen or vascular injury which may overshadow the neurologic damage both diagnostically and in the demand for prompt treatment. Many of the doctors who train at this institution will go out into communities where competent neurosurgical consultation is not readily available. A working understanding of the principles involved in diagnosis and treatment of these injuries is essential to every surgeon called upon to care for the traumatized patient.

With us today is an authority whose experience and teaching in this phase of trauma are unsurpassed. I have asked the chairman of our department, Dr. Lichtenstein, a member of his faculty for many years, to introduce our guest.

Dr. Manuel E. Lichtenstein, Chairman of the Department of Surgery, Cook County Hospital: This introduction will be brief because you know the speaker. Since the inception of these Conferences, it has been our objective to acquaint all the interns and residents trained here not only with the personnel of this hospital but of all the medical schools in the Chicago area. We think the future bodes well for Chicago as a city of great medical centers. This is a large city and these centers are distributed throughout the entire metropolitan area. We have invited professors from other medical schools to speak to you so that you may know who they are, what their accomplishments are, and how they fit into the teaching programs of this and other institutions.

Today we are fortunate in having with us the chairman of the department of surgery in one of the great medical schools of this country. He has been connected with the training of surgeons and the teaching of surgery for many years, and he is known throughout the world for his contributions, achievements, and his close association with the American College of Surgeons. He is

editor of the most widely circulated surgical journal in the world, and his influence in elevating the practice of surgery to its present great heights in America make him an outstanding personality in the field of surgical education. It is a pleasure to have him with us, and I hope this Conference will bespeak a closer relationship with Northwestern University Medical School and this hospital in the future. It is my privilege to introduce Dr. Loyal Davis to you.

CASE 1

Dr. Edward Beheler, Surgical Resident: This 35 year old Negro male entered Cook County Hospital on November 12, 1959, following accidental bullet wounds of the right hip, flank, and hand incurred 3 hours previously. On admission his general condition was excellent, and his complaints were confined to the right foot which was the site of excruciating knife-like pains from the ankle downward. There were three entrance wounds in the posterolateral aspect of the right thigh just below the level of the gluteal crease. Two wounds of exit could be noted on the anterior aspect of the thigh. There was no evidence of sensory or motor loss in the right lower extremity, and all pulses were readily palpable. Roentgenograms showed metallic fragments just beneath the ischial tuberosity posteriorily.

All wounds were cleansed, irrigated and superficially debrided, and permitted to heal by secondary intention without incident. Complaints of severe foot pain persisted, however, and rapidly became unresponsive to the usual pain medication. The foot was warm, markedly hyperesthetic, but initially showed no objective evidence of peripheral nerve deficit. The slightest manipulation or movement was resisted, and the patient complained that even loud sounds would aggravate his discomfort.

Prompt relief of pain was temporarily obtained by lumbar sympathetic blocks with 1 per cent procaine. However, right lumbar sypmathectomy on December 7, 1959, was associated with only temporary relief.

Dr. Freeark: We would like to show the patient at this time to give you an idea of the area involved and the problem he presented. (Patient brought in here.) You will note the three separate entrance wounds which healed without incident, as did the two exit wounds on the anterior thigh. Because of the inaccessibility of the area involved and the absence of definite neurologic, bony or vascular deficit, his initial treatment consisted of limited debridement and the usual supportive measures.

Now nearly eight weeks later you will note that considerable disuse atrophy has occurred. Sensation to cotton touch, and pin prick is normal throughout the thigh and leg but is exaggerated in the foot, particularly on the sole. Reflexes were intact initially but are markedly depressed at present.

The x-ray films of this area are on the view box, and the location of the metal fragments may be seen.

Now we need the assistance of Dr. Davis.

Dr. Loyal Davis: Good morning. The last time I stood here was in 1919 as assistant to Dr. James Neff. He was performing a section of the posterior root of the trigeminal nerve. I was his first assistant. I will not enlarge on the outcome of that case some 40 years ago.

The case you have presented is an interesting one. I am sure there is no one here who does not know that this is a man with causalgia. The first patient I ever saw with causalgia was in this hospital on Ward 34. It followed a stab wound of the forearm in which the median nerve had been injured. That was the first time I had ever seen a Weir-Mitchell causalgia, and I wish that it had been the last. They are extremely unhappy patients.

Does it hurt you now when I talk too loud?

Patient: No.

Dr. Davis: But it did at first?

Patient: Yes.

Dr. Davis: Usually the patient complains even when anything wet is put on the extremity. Does that hurt you (placing a cold metal instrument against the foot)?

Patient: It makes it feel hot.

Dr. Davis: Are you in pain now?

Patient: It hurts on the bottom of my foot.

Dr. Davis: Obviously the first thing to know is that peripheral nerve injuries are not painful except for the causalgia type of peripheral nerve injury described by Weir-Mitchell. No one has ever improved on his original description. This is an excruciating pain which is aggravated by sound, by the touch of bed clothes, by people coming near the bed. You will find some of these patients with their hands or feet in pails of cold

water; others will have them in hot water, and there will be still another group who cannot stand anything wet on the skin of the affected extremity. (The patient was taken out here.)

There are only two nerves in which causalgia occurs: the median of the upper extremity and the sciatic in the lower extremity. When the latter is involved, it is only injury of the tibial division which is accompanied by this type of pain.

Causalgia in peripheral nerve injuries was encountered in World War I, but far greater experience was gained during World War II from work done at the Percy Jones Army General Hospital by Dr. Frank Mayfield, a Cincinnati neurosurgeon who had a series of patients with causalgia under his care. Some of these extremities and hands and feet were red, sweating profusely, and held immobile; others were pale, dry, cool, and painful.

It is difficult to explain why one patient with all the signs of vasodilatation in the extremity is relieved of causalgia by sympathectomy and another individual with causalgia and signs of vasoconstriction is also relieved by sympathectomy. One would expect that, since sympathectomy produces vasodilatation, only the individual with vasoconstriction showing pallor and dryness and small arterial pulses would be relieved and not the man with the evident signs of vasodilatation. Nevertheless, the clinical result was that relief was obtained in both groups.

It is much more difficult to relieve a patient with causalgia from a peripheral nerve lesion in the upper extremity by sympathectomy because of the marked difference in innervation of the sympathetic system to the fore limb. It is necessary to go lower on the chain than one would expect in order to obtain an effective sympathectomy in the upper extremity. The results from sympathectomy for vascular disease of the extremities have always been better in the lower than in the upper limbs. The sympathectomy should include the lumbar 1, 2, and 3 ganglia in the lower extremity and the thoracic 1, 2, and 3 ganglia in the upper extremity.

The patient presented today was relieved by novacaine injection, and one would expect him to be relieved, therefore, by sympathectomy. We are told that he was not. This may be the result of an incomplete sympathectomy. If complete, there should be definite evidence that the extremity is sympathectomized. There should be a rise in skin temperature, and the extremity should feel warm. It appears that this has been accomplished and this is the best treatment for him. But the question is: Has the time since operation been long enough to assess results? I would give him plenty of time because, associated with this type of pain, there is a definite psychologic state. I would give him plenty of time to see if this relief will take place. If it does not and if his pain is as it was before, then I would explore the sciatic nerve. I assume from the incision that this was explored.

Dr. Freeark: One might say he was explored in desperation. The service had run the gamut of indirect therapeutic procedures to no avail. The patient remained in constant pain which bordered on an emotional crisis, and his narcotic demands seemed destined for an addiction problem. The results of sympathectomy were disappointing, and two weeks later the sciatic nerve was explored through a posterior approach under general endotracheal anethesia. The sciatic nerve at the level of the gluteal crease was found to be the site of a bulbous swelling 1.5 cm. in length. Imbedded in this area of nerve were several small metallic fragments of bullet. The dilemma was obvious. Should the surgeon elect to resect this neuroma and attempt end-to-end repair of the sciatic nerve, or was further conservation in order?

Dr. Davis: If I understand you correctly, there was a neuroma of the sciatic nerve without the nerve having been divided, and in this bulbous enlargement were metal fragments from the bullets. Unders these circumstances I would assume that he has a neurologic deficit that was perhaps not detected. I do not think this is totally the atrophy of disuse, and since I failed to elicit an Achilles reflex, I believe he has a loss of peripheral nerve function. If he persists in having pain, I would resect the neuroma and resuture the nerve. I do not think neurolysis should be done. This simply refers to making an incision in the neuroma and taking out the fragments. That is not very satisfactory. Obviously the length of this neuroma will influence the amount of scar tissue which must be removed. The gap in the nerve may have to be bridged by mobilization of the proximal and distal nerve segments and end-to-end suturing. Nerve grafts are not effective because an autogenous graft of

this size would not be available, and stored homografts of the sciatic or any other nerve are useless. An autogenous nerve of the same diameter as the sciatic nerve is necessary and not a group of small nerves, termed a cable graft. In our experience homogenous grafts are not absorbed, but the pattern of regenerating nerve fibers from the central end is one which is obstructive and, therefore, clinically unsuccessful. It is best to do an end-to-end suture and, if the gap cannot be bridged by mobilizing the nerve, then there is no good way of repairing that nerve successfully. If these things fail, then the foot must be fixed so that the patient is not handicapped by foot drop.

In civilian life, peripheral nerve injuries of this type with causalgia are not common. As you know, most of the peripheral nerve lesions occur at the wrist in civilian life and involve chiefly the median and ulnar nerves.

In summary, let me say that before exploration of this nerve I would have requested complete electrodiagnostic studies of the muscles innervated by the sciatic. I would have tried sympathectomy, as you have, and I would allow plenty of time for the maximum benefits to occur. The patient should be sent to physical therapy, given plenty of encouragement, and every effort should be made to relieve his anxiety and tension produced by this causalgic pain. If all these things fail, I would resect the neuroma and resuture the nerve.

Dr. S. Howard Armstrong, Jr., Director of Medical Education, Cook County Hospital: In the suture line do you use tantalum?

Dr. Davis: No. Dr. Armstrong is referring to the fact that during the war, men who had not seen many peripheral nerve injuries took a piece of tantalum wire or any kind of wire suture and passed it through the nerve and tried to anchor the nerve ends. The moment you put a needle even without a suture through the nerve you have produced an intraneural lesion of the nerve. Every time you pick up the nerve with a hemostat you have produced a lesion. Every time you inject the nerve with saline solution you produce a lesion. So when nerve suture is done only the epineurium is sutured.

Dr. Armstrong may have been referring also to the practice of wrapping the suture line with something like tantalum or other material in an attempt to prevent scarring at the anastomotic line. In fact, during the war all sorts of things were used with the idea of keeping the scar tissue from growing into the suture line. But what happened was that this material plastered itself around the suture line and the nerve fibers were never able to penetrate the anastomotic line. Do not put anything around the repair and do not put a suture into the nerve. Do an end-to-end suture of the epineurium with fine silk suture and as little trauma as possible.

Just remember these simple things: If you see a patient with a wrist laceration and you want to know whether the ulnar nerve is injured, prick him on the palmar surface of the little finger and if he cannot feel it, he has ulnar nerve injury. Loss of sensation on pricking the palmar surface of the index finger means median nerve injury. It is analgesia in the area between the thumb and first finger on the dorsal surface of the hand that indicates injury of the radial nerve. This may be difficult to detect; but if the injured man cannot extend his wrist, he has a definite radial nerve palsy. There is no excuse for anyone to miss a nerve injury when the patient has a laceration of the wrist. There is no reason to assume that a man with injury to his lower extremity does not have nerve injury when he has been shot in the thigh. It is up to you to prove that he has not. This particular man may have had a foot drop or a diminished Achilles reflex; but if you tested him for sensation, you might be lulled into a false sense of security if the area of isolated supply of the sciatic nerve was not tested. In the radial and sciatic nerve lesions, the motor deficit is the most reliable and most easily determined.

Dr. Freeark: At surgery this patient underwent neurolysis. The area of swelling was mobilized and the nerve fibers gently teased apart to permit extraction of as many metallic fragments as possible. The neuroma was not resected.

Dr. Davis, let us assume that prior to surgery there was no gross neurologic deficit, no foot drop or detectable sensory loss. The surgeons found this neuroma, and they wondered how good a sciatic repair at this level would be. This is a long way for a nerve to travel. If we accept the rule that nerves regenerate on the average of one inch a month, will there be any muscles left for the regenerated nerve to innervate? Is the fate of the repaired sciatic nerve a happy one under these circumstances?

Dr. Davis: Yes, although all the patients have to be rehabilitated and they all have to be splinted properly. The bad results in peripheral nerve surgery come from ulnar and median nerve injuries. If those lesions have existed for any length of time and the intricate small muscles of the hand have wasted and become atrophic, their rehabilitation is difficult. You may judge the result in one man's hand as not good and, therefore, you say the peripheral nerve suture is unsuccessful. But this is not quite the case. It depends on the patient's occupation to some extent. If he is a typist or a pianist or a violin player, then the result may not be good, but if he is a laborer and has function of large movements of the hand and has some return of sensation, then he has a good, useful hand. Even though the small hand muscles have not been fully restored, the laborer can work well. So one may expect a good suture repair, with careful apposition of both nerve endings free of tension, to result in a satisfactory restoration of sciatic function.

It has been said that you can place nerves under tension and stretch them to obtain end-to-end suture. If a nerve is stretched, it is the same thing as putting a suture through it or pinching it: you produce a lesion. It just does not make sense to stretch the nerve to get it sutured end to end. It requires careful, gentle surgery. Some of these nerve injuries cannot be repaired, and the patient needs orthopedic measures with fixation of the joints to obtain a maximal functioning extremity.

At the present time I would leave this man alone, especially if there is evidence that the pain is diminishing. But you must treat him as a psychoneurotic individual. He must go to physical therapy, and there they must give him things to do and disabuse him of his preoccupation with this extremity. There is no question that he had pain, but I would doubt that any pain at present is like the original pain. All the personnel who deal with him should treat him kindly but firmly. He cannot be coddled or permitted special considerations because of his difficulties. There is a large emotional component to the type of pain which constitutes the symptom complex named causalgia.

Dr. Freeark: That has certainly been the case with this patient. He responded quite nicely from the pain standpoint to a change in interns. He had had an extremely conscientious intern who gave him excellent care and study. With a change of service there has been an understandable lack of personal interest on the part of the new intern and the patient's pain has improved a great deal. He is not being neglected, but he is not getting as much attention as he did before.

Dr. Davis, we still see gunshot wounds at this hospital. What about the management of a peripheral nerve injury with immediate and complete paralysis? Should this be explored primarily and should repair always be undertaken?

Dr. Davis: Repair should be immediate, provided it is a relatively clean wound or can be made clean. If the patient has a compound injury with destructive involvement of the muscle and other soft tissues and if that injury has been present six hours or more, I would consider it an infected wound which I could not make clean by careful scrubbing with soap and water. Under six hours, I would assume that by careful cleansing and religious application of all of the principles of wound debridement the nerve could be repaired immediately. Any peripheral nerve injury under existing favorable circumstances. Should be operated upon immediately and immediate suture made. I do not believe that peripheral nerve injuries should be deliberately delayed in treatment. This is in conflict with some British views, but I do not believe in it.

On the other hand, if the wound cannot be cleansed satisfactorily, I would delay the nerve suture, although in some instances I doubt that I would even then. I would suture the nerve end-to-end, realizing that there would probably be infection and there would be a large neuroma develop; but I would have it end-to-end with little retraction, and I would resect the neuroma and resuture at a later date.

The important thing is to be alert to possible nerve injuries. Do not miss a peripheral nerve injury because you failed to look for it.

CASE 2

Dr. Richard Grossman, Surgical Resident: This 32 year old Negro male entered Cook County Hospital on December 5, 1959, two hours after a fall in his home which resulted in loss of consciousness and complete quadriplegia. He regained consciousness while being transported to the hospital and recalled only that he

was playing on a couch with his infant nephew and rolled to the floor, striking the lower back.

Physical examination revealed a well developed, well nourished Negro male in moderate respiratory distress with quadriplegia, diaphragmatic respirations, and a sensory level at the clavicles.

Roentgenograms of the cervical spine were interpreted as showing no abnormalities. Lumbar puncture disclosed grossly bloody fluid with normal dynamics.

Dr. Freeark: The relatives who accompanied this patient to the hospital gave conflicting accounts of the severity of his fall. He was variously described as having turned a complete somersault and landing on his cervical spine, to simply sliding off the couch onto his buttocks. Regardless of the mechanism of injury, the cervical spine x-rays were not impressive.

This was a tragic story in a young father with a devoted family. There was great enthusiasm for surgical intervention on the grounds of "What have we got to lose?" Will you give us your opinion of the proper management of such a case?

Dr. Davis: It is always dangerous to treat people by analogy; but as your experience increases, you will be struck by the fact that there are similar instances and similar findings in patients. This is what makes clinical experience valuable. You store this information away and compare it, but you do not say, "I did that once, and I will do it again in the next case."

When Dr. Freeark told me about this patient over the phone, I could not keep from remembering a patient of mine, a young lawyer, perfectly well so far as anyone knew. He was standing in front of the judge and jury, pleading a case. Of course, all lawyers get excited; this is part of their profession. This man suddenly collapsed and fell to the floor. It was thought that he had a coronary occlusion, and so the Fire Department pulmotor squad was called. He survived this heroic first aid treatment and was brought to the hospital, quadriplegic and with a sensory loss below the third thoracic dermatome. On spinal puncture we found grossly bloody fluid. His Queckenstedt test was perfectly normal.

A great deal of controversy has always surrounded patients such as this. There is one indication for operation following trauma to the spinal cord and that is the presence of complete or incomplete subarachnoid space block. The reason for this is that the only thing a surgeon can do in the presence of spinal cord trauma is to remove the pressure upon the spinal cord. He cannot suture the spinal cord. The spinal cord will not grow together because its fibers do not have neurolemmal sheaths. The surgeon can only remove pressure on the cord. If there is pressure enough to produce incomplete or complete block, then the surgeon has an indication to operate.

These two patients are exceptions because it is not clear whether this man had an injury; my patient did not have an injury. The latter did not have a dislocation of the cervical spine or fracture of the cervical spine, and he had a normal manometric study. Either patient could have had an angioma of the cord in which a sudden rise in intraspinal pressure would cause the rupture of a vessel. Could the anterior spinal artery have thrombosed? Yes, it could but there was bleeding into the subarachnoid space. If I were the patient under these circumstances with blood in my spinal fluid, I would want a careful surgeon to use every method of diagnosis available to determine the nature of the lesion and see if he could determine the cause of bleeding and do something about it. I would want him to look at that level of the spinal cord which was injured.

From the beginning both patients had a complete quadriplegia. My patient survived and later the neurologic symptoms were those of a motor lesion on one side and a sensory lesion on the other. I operated upon him and removed the subarachnoid blood, but I could not find the source of the bleeding. An angioma of the cord was not found. I do not know the cause of my patient's bleeding, and I shall be interested to know if the autopsy disclosed the cause of the bleeding in this patient. My patient has improved so that he is practicing law again. He is in a wheelchair, but he has recovered a good deal of the use of his upper extremity on the side of the sensory disturbance but less so on the side of the motor lesion.

Dr. Armstrong: How big a laminectomy do you make in such a case, how many segments?

Dr. Davis: I went two vertebrae above and two below the sensory level, and I would go more than that if I had to.

Dr. Paul R. Rosenbluth, Chairman of the Department of Neurosurgery, Cook County Hospital: This was an extremely heavy set, muscular man who was turning a somersault for this child.

He fell off the sofa and came down on his neck. I think this is different than a spontaneous affair where a man collapses. We felt there was a definite history of trauma. X-rays were taken but the films were not particularly satisfactory, but we could see no obvious dislocation.

Would you comment on the use of Krutchfield tongs when you suspect cervical fracture? This man had been put in tongs, but when we found no fracture they were removed. Queckenstedt was normal and we decided against surgery.

Dr. Davis: Of course, there was no accurate indication for operation. In some of these patients, the assumption is made that the man has a quadriplegia or paraplegia due to a complete anatomical lesion of the cord and that nothing can be done for him. I don't believe we have a right to assume that. Therefore, the best guide is to use the Queckenstedt as an indication for surgery. I did not follow this rule because my man had no block. He might have recovered just as he has if we had not operated upon him. However, I don't think I increased his lesion, and we may have helped it. It is a question of judgment.

Dr. Freeark: This patient expired rather suddenly during a tracheostomy necessitated by the need for tracheal toilet. The autopsy was performed by the Coroner's office, and all the details were not available. We were told that there was a linear fracture of the vertebral body of the 5th cervical vertebra and that the cervical segment of the cord was completely liquefied. I am still unable to locate a fracture line on the x-ray film.

Question: What type of anesthesia do you use in cases of trauma of the neck where you feel you should do cervical laminectomy?

Dr. Davis: I would prefer to do it under local anesthesia. That is what we used in the case I mentioned. We did not put a tracheal tube down.

I am very much interested in the case reported today, and particularly in the demonstration of the fracture line because this is just enough evidence of trauma to explain the damage. I just don't know about my patient. We tried to obtain a history of recent trauma without success, and x-ray films of the spine were within normal.

Question: Suppose this had been a lower type of lesion; would you have explored him with these spinal fluid findings?

Dr. Davis: No, and I emphasize again that a complete or incomplete subarachnoid space block is the most valuable indication for surgery. At times you must put yourself in the patient's place and say, What would I want done? Then surgical indication becomes a matter of surgical judgment, experience and surgical conscience. There are times when you are without an accurate preoperative diagnosis and the surgeon must take over from the medical man and attempt to find out what is going on, but there are two guiding rules in the surgical treatment of spinal cord injury: Don't perform a laminectomy in the presence of spinal cord injury unless there is a demonstrable block in the subarachnoid space which you, the surgeon, can mechanically remove by decompression laminectomy. Secondly, don't assume that because the patient is totally paralyzed that there is a complete anatomical section of the spinal cord. It may be completely physiologic. Therefore, the presence of a subarachnoid space block is the reason to operate.

In the presence of a fracture-dislocation of the cervical spine, I would put the patient in Krutchfield tongs to reduce it and reduce the subarachnoid space block. If by traction and extension the block disappears, I would not consider operating. If it does not disappear, I would perform a laminectomy.

Perforation of the Rectum by Enema Tip

James Scott, M.D., *Dwight*

PERFORATION of the anus and rectum by an enema tip is a rare and serious injury. In 1956, Large and Muckheiber, were able to collect only 28 cases and they reported one of their own. During recent years, further case reports remained few and far between.[2,3] But, despite the scarcity of publications on this subject, most surgeons feel that numerous cases remain unreported and thus the true frequency unknown.

R.A.S.: No. A815. This 63 year old white male patient was admitted to the VA Hospital at Dwight in May of 1959 with signs and symptoms of a far advanced multiple sclerosis. He was complaining of failing vision and of difficulty in starting the urinary stream. Because of constipation, the patient frequently required laxatives and enemas. The lower extremities were paralyzed and there was marked motor weakness of the upper extremities.

The routine laboratory data were within normal limits. On June 29, 1959, a left senile cataract was extracted and recovery was eventful. On July 8, while an orderly was administering a sodium phosphate enema in a disposable plastic container, the patient experienced a sudden pain in the anus. Four hours later, pain became severe, the scrotum and penis were swollen, the patient was unable to urinate, and the temperature rose to 101° F. Eight hours after the enema, the patient had several involuntary bowel movements and he experienced moderate lower abdominal discomfort and nausea.

A retention catheter was inserted into the urinary bladder and a surgical consultation was requested. Examination revealed an apprehensive and acutely ill patient. The pulse was 120 per minute, the temperature 101° F., and the white blood count 13,000 per cu. mm. of blood. The abdomen was soft, bowel sounds were present, and the penis, scrotum, and perineum were edematous according to the distribution of the Colles' fascia. Examination of the rectum revealed perforation of the anterior rectal wall, approximately four centimeters from the anal opening.

Treatment consisted of intravenous fluids and large doses of penicillin and streptomycin. Later treatment consisted of regular diet, mineral oil, and sitz baths. One week following this management, abdominal discomfort, nausea, fever, and scrotal swelling had subsided. Proctoscopic examination confirmed the perforation of the rectal wall and an anterior abscess cavity. The size of the cavity, drainage, and the anal incontinence subsided gradually. Two months after the injury, the patient again experienced the urge to defecate and he had one or two stools daily or every other day. The abscess cavity was almost healed and the patient was discharged.

Department of Surgery, VA Hospital, Dwight, Ill.

Comments

Perforation may be caused by a rectal tube, by the hard tip of an enema syringe, or by the semirigid tip of a disposable enema container. Patients requiring frequent rectal irrigations are especially exposed to this type of injury. Lack of skill in administering the enema may or may not be a factor as a diseased rectal wall predisposes to perforation. While all perforations of the lower gastrointestinal tract are serious, enema injuries are even more dangerous because the enema fluid disseminates the fecal material into the perianal or perirectal tissues. The injuries are limited to a few centimeters from the anal opening. The tip may perforate into the abdominal cavity, the perirectal tissues, or adjacent viscera. Perforations of the anal canal below the levator ani muscle are rare and according to Large and Muckheiber, no mortality was observed. Resulting abscess, stricture, and anal incontinence require appropriate management.

Summary

Perforation of the anus or the rectum by an enema tip is a rare and serious injury.

One case of perforation of the rectum by the semirigid tip of a disposable plastic enema container is reported.

REFERENCES

1. Large, P. G. and Muckheiber, W. J.: Injury to the Rectum and Anal Canal by Enema Syringes, Lancet 2:596 (Sept. 22), 1956.
2. Szunyogh, B.: Enema Injuries, Am. J. Proct. 9:303, 1958.
3. Spiro, R. K.: Perforation of the Rectum Following Barium Enema, Am. J. Gastroenter. 30:540, 1958.

EDITORIALS

Implications for medical PR

The modern PR man serves his client's interest best in telling the truth even about unfavorable occurrence, and by bringing out favorable points in his client's interest—thus removing some of the burdens the bad publicity created.*

The drug industry has had a difficult time with its PR for a specific reason. Each company is a business with officers, directors, and stockholders. There were mergers, stock quotations; and in time huge profits rather than the integrity of the manufacturer became synonymous with the pharmaceutical industry. It is no wonder that so many persons were shocked by the congressional investigations on drug profits.

The commercial skirt of the drug industry was bound to show as more and more businessmen assumed control. It was unfortunate that their PR departments failed to look ahead or to appreciate the strong connotation that the word *welfare* has in the minds of the public and their politicians.

PR is a specialized field and goes deeper than preparing press releases. According to the Bulletin, it is more than eulogizing speeches, and glittering and aimless conventions. The PR consultant must know the objectives of the organization or profession he serves and be sold on the goodness of their projects ideals, and ethics.

He should become more intimate with the organization and participate in its policy making. He should recognize not only the employer's self interest but the responsibilities and obligations to those the employer serves.

All of this is applicable to medical PR. We must think of the future as well as the present. We have a story to tell, but it must include material that will be of benefit or impress the well or healthy section of our voting public. Sick people are apt to be sympathetic to modern medical practice but the majority of people have not seen their physicians for some time. They must be served a different dish in order to understand that our interests will benefit them in the future.

*Public Relations and Private Enlightenment, Monthly Bulletin of Di Cyan & Brown, No. 92 (Feb., 1960).

Natural childbirth

Not too long ago the delivery of a baby was no momentous occasion to anyone other than the parents. The birth most often occurred in the home under the guidance of an inexperienced "granny," a trained midwife, or more rarely a physician. Only 25 years ago almost 70 women lost their lives in every 10,000 live births and countless numbers were irreparably damaged. Contrast this with a maternal mortality of less than 4 per 10,000 in 1959.

Intelligent prenatal care is a development of the present century. The hospitalization of more than 95 per cent of our mothers for delivery was precipitated by the Second World War. The advances of the medical sciences which have provided antibiotic drugs, safe blood replacement, intelligent anesthesia, and new knowledge concerning many facets of human reproduction are of recent origin.

In our zeal to combat the shocking loss of life and serious damage to mother and baby, the birth process has been safeguarded by all the scientific and technical developments of the modern hospital environment. More and more powerful drugs are available to combat the pain and anguish associated with labor. The birth of a baby today is safe but has become a sterile experience for too many mothers.

The last decade has witnessed increasing interest by the public and to a lesser extent by the profession in the psychological and emotional aspects of human reproduction. Sparked by the crusading Grantley Dick Read, who died on June 11, 1959, the simple philosophy which he

introduced to the world in his first book entitled "Natural Childbirth" in 1932 has spread widely in this country and around the world. His "Fear-Pain-Tension Syndrome" has found ready acceptance by many physicians in our country, and his books and lectures to the public have aroused their interest in making the birth of a baby a happy, rewarding, and exciting experience as well as a safe one.

There is no doubt that the fear of childbirth is brought about by ignorance and misinformation. It is natural to be afraid of the unknown. Fear can be banished by education. This should rightfully begin in childhood, continue through adolescence, and become the highlight of modern maternity care. The public has become increasingly aware of the need to understand everything about birth and the care of the new baby so that they can be better patients, better mothers and fathers, more intelligent citizens.

Pain has been indelibly identified with the birth process since the dawn of history. Pain and uterine contractions have been synonomous in most languages of the world and such usage should be banished in obstetries. How can one think of natural childbirth when the nurse or doctor greets the mother on admission to the maternity with the following questions: When did your pains start? How often do they come? How long do they last? Pain, pain, pain has become symbolic of the birth process. Uterine contractions can be uncomfortable, and the stretching of the soft tissues as the baby moves down the birth canal may be difficult to tolerate. However, a proper understanding of the elementary physiology and anatomy of pregnancy, labor, and delivery will give the patient confidence in herself and her attendants. The familiarity with physical exercises especially those used in the correct position for the second stage will relieve some of the discomfort. Furthermore, the feeling that she can help herself to some extent and that she is an active participant in life's most important event will engender confidence and satisfaction. Safe analgesic drugs and anesthetic agents are always available when the discomfort becomes unbearable. Thus, the pain associated with labor and delivery can be controlled by proper preparation of the mother and intelligent medical management.

There is no doubt that tension may alter the labor mechanism, retard normal progress, and increase the incidence of complications. The mother's preparation for labor should include the art of relaxation so important today in our complex social environment. The well informed, well prepared patient will cooperate with the physician intelligently. The premature use of drugs will become unnecessary, and they will be reserved for timely application. Emotional support of the patient by the husband, the nurse, the physician will go far to reduce tension. The rewards of a successful delivery will more than compensate for the discomfort inherent in the physiologic process of human reproduction.

Natural childbirth does not mean that the mother should deliver her baby spontaneously and by her own efforts regardless of the price in damage to soft structures, to the baby, or to her emotional well-being. Nor does a spontaneous birth exemplify a mother's supreme achievement. It should connote modern maternity care in all its aspects. Education for parenthood is the keynote of intelligent obstetrical care. The mother should attend preparation for labor classes if they are available in the community. If formal instruction is not available, her doctor should recommend one of several good books on the subject, and each prenatal visit should be utilized to answer the mother's questions, to make suggestions, and to give advice. She should have a thorough understanding of her pelvic organs, the simple physiology of pregnancy, the mechanism of labor, and how she can be helpful to herself and her physician so that complications may be minimized.

A rehearsal for the advent of labor will help to remove some of the anxiety concerning the labor process. It is psychologically beneficial to have the parents visit the hospital, see the labor room, the delivery room, the nursery, and perhaps the happy mothers present. The patient in labor needs emotional support which can be provided best by the husband, the physician, the nurse. She should know that labor is a normal, natural process and that she is exercising life's greatest role, the perpetuation of the race.

There is no doubt that modern and safe maternity care is the most important business in America today, and it will grow tremendously in the immediate years ahead. It is everybody's business — parents, grandparents, the professions, and society at large.

M. Edward Davis, M.D.

Recent advances in repository treatments in allergy

In the August, 1959, issue of the Illinois State Medical Journal we summarized the status of repository therapy. Because of the rapid changes in this field, we have now been asked to review the subject.

A year ago few physicians had used the procedure, and the thought of giving a single injection containing a large amout of antigen to extremely sensitive patients made the rest of us cringe. Methods of preventing reactions were uncertain, and the efficiency of the material not well established. Now a number of allergists throughout the country have used repository treatments in hundreds of patients with few reactions and no deaths. We have found the effectiveness approximates that achieved with aqueous extracts. In short, we now know that repository treatment is both safe and effective in proper hands.

There are still many unanswered questions. Each allergist seems to have developed his own variations in dosages and premedication, but the preparation of a good emulsion remains the crux of our problems. If we were to give a hundred times the shocking dose of an antigen in an emulsion form and only 1 per cent was not emulsified, obviously shock might occur. We need far greater than 99 per cent emulsification of the material so that the relatively small amounts immediately available are not sufficient to lead to disaster. A poor emulsion means reactions and poor results, whereas a good emulsion means an ever-expanding horizon of usefulness. Machines for making a good emulsion have not yet been perfected, and making emulsions by hand is successful but arduous.

Most of us have used only repository ragweed, grass, and trees; our experience with molds, animal danders and most other antigens is meager. We look forward to the day when we will be able to immunize the cat-sensitive asthmatic with a single annual injection of cat dander extract; this has already been done by a few investigators.

One last conjecture might be pertinent. Is it not possible that emulsion bases may eventually replace aqueous solutions for routine immunizations? Might not the efficacy of influenza or poliomyelitis vaccine be enhanced if it were given as an emulsion? Trials with influenza vaccine in an emulsion base are already in progress and await clinical evaluation.

Certainly this field merits much greater investigation, but at this time we can look back over the past year and feel that allergists have indeed taken a major step forward.

Donald L. Unger, M.D.
Leon Unger, M.D.

Lunchroom revolution

Candy bars will no longer be sold in Chicago elementary school lunchrooms. They have been tempting children at the rate of $17,533 yearly with $5,000 profit to the Board of Education. The candy profit in high schools during 1959 was $57,000.

Some of the success for this program stems from the work of our Dr. John L. Reichart, who maintains that candy in the lunchrooms is more tempting than apples, milk, and similar healthful items. In this we agree. The dentists also will be pleased because candy and carbonated beverages are high on their list of caries-producing agents.

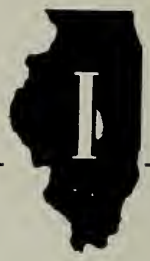
Generosity pays

Americans were generous to the tune of $7.8 billion last year, $700 million more than they gave to philanthropy in 1958, the American Association of Fund-Raising Counsel reports. Since it may be "more blessed to given than receive," many were truly blessed. Interestingly, religion received about half the total; welfare, 16 per cent; education, 15 per cent. Health philanthropy ranked only a little below education — 14 per cent.

Mid-April, generous Americans were made to realize they were twice blessed when they reported their yearly gains for Washington and points east.

Many physicians have been criticized for lack of charity in contributing to fund-raising organizations. On the other hand, has anyone ever calculated the amount of free time and talent physicians give in clinics, hospitals, and other charitable institutions throughout the year? Since time means money, the physician would appreciate some means of recognition from the Treasury Department for his personal charity.

From the Secretary's Office



Notice to County Medical Societies

Sometime in April there will be an open meeting in your county called by the I.P.A.C. to consider material for the White House Conference on Aging, which has been announced for January 1961.

Physical and Mental Health are two of the subjects to be considered, and it is highly important for the medical profession to be well represented at these county meetings. In May there will be six regional meetings. These will not be open but will be by invitation. Material from the county meetings will be considered at the regional meetings and recommendations made to the state level.

Blue Shield plan offered For persons 65 or over

A low cost voluntary insurance program designed to meet surgical and in-hospital medical expenses of all persons 65 years old or over has been announced by the Illinois State Medical Society.

Prepared on instructions from the House of Delegates, the project will be underwritten by the Blue Shield Plan of Illinois Medical Service. The monthly cost per person will be about $1.65.

The insured person may receive in a 90-day period a maximum benefit of $200, according to a schedule of surgical allowances similar to that of the general Blue Shield certificate. The plan also provides 30 days of in-hospital medical care benefits per hospital admission, including an allowance of $5 for each of the first five daily visits and $3 for each of the next 25 daily visits. Then, after the patient has been out of the hospital for 90 days and is readmitted, he may receive 30 days of in-hospital medical care benefits again.

Other professional services for which a schedule of allowances has been worked out include: diagnostic x-ray service, radiation therapy, clinical and surgical pathology, anesthesia, shock therapy, and diagnostic skin tests.

"The plan has been developed to make it possible for the older person who needs hospitalization for surgical or medical care to have practical, realistic insurance," Dr. Joseph T. O'Neill, president of the ISMS, said.

"The schedules have been worked out with the idea that the allowances will be in line with fees charged by many physicians for people with a low income."

All members of the Society have been informed about the program and have been asked to sign cards agreeing to accept as payment-in-full the schedule of fees in these cases where the patient falls within a low income and assets group. The maximum is $2,000 annual income and $15,000 assets for individuals, and $3,000 income and $20,000 assets for couples. For those who do not fall within that category, the plan is an indemnity one.

It is urged that physicians who desire to participate in the program, which is entirely volun-

tary, return their signed cards to Blue Shield immediately.

Many physicians are confused about this voluntary insurance program. It is a formalized plan of what physicians have done for many years. They always have taken care of their older patients of low income at a reduced fee, but it is necessary now to have it in writing.

In all probability only a limited number will be eligible. The indigent patient is already provided for by public aid. The financially secure will take care of themselves.

Society joins crash injury project

Starting April 1, 1960, Illinois has become the 18th state to participate in the Interstate Automotive Crash Injury Research data-collecting system coordinated by Cornell University. This state undertaking is sponsored by the Illinois State Highway Police, Department of Public Health, Hospital Association, and State Medical Society.

The purpose of the program is to obtain reliable data on frequency, nature and specific causes of injury to occupants of passenger cars involved in automobile accidents. Data from cooperating states have formed a basis by which automobile manufacturers have made important interior design changes in passenger cars manufactured during the past four years. These are specifically engineered to provide greater protection to occupants during accidents. Reliable information being obtained on the degree of protection offered by these items which includes seat belts, improved door latches, energy-absorbing steering wheels, padding, etc., is most encouraging. A reduction up to 29% in the risk of serious through fatal injuries has been seen in sample accidents involving recent model automobiles analyzed through this project.

The first six months the program in Illinois will be conducted in the following counties: Ford, Iroquois, Kankakee, Livingston, McLean, Fulton, Marshall, Peoria, Putnam, Stark, Tazewell, and Woodford.

Information was sent to all physicians in these counties prior to the starting date. The work is being cleared by the Illinois State Medical Society Committee on Traffic Safety, Dr. F. Garm Norbury of Jacksonville, chairman.

Don't miss

The First HAROLD M. CAMP MEMORIAL LECTURE

Michael E. DeBakey, Professor of Surgery, Baylor University, Houston

General Assembly, Wednesday morning, May 25

Ballroom Sherman Hotel

1960 Annual Meeting, Illinois State Medical Society

May 23, 24, 25, 26, Hotel Sherman, Chicago

Section Meetings

(Continued from March Journal)

Section on Anesthesiology

James Felts, Chairman ..... Marion
Freda B. Morgan, Secretary ..... Chicago

Tuesday Afternoon, May 24
Old Chicago Room 101

3:00 p.m. "Tranquilizers and Anesthesia"
Emanuel M. Papper, New York
Professor of Anesthesiology, Columbia University

"Newer Narcotics and Analgesics"
Max Sadove, Chicago
Professor of Anesthesiology, University of Illinois College of Medicine

"Intensive Care Units in the Community Hospital"
William K. Stephen, Decatur

Business meeting and election of 1961 section officers

Section on Allergy

Thursday Morning, May 26
Gold Room 114

9:00 a.m. "The Present Status of Repository Ragweed Emulsion Therapy for Hay Fever"
Alan R. Feinberg, M.S., M.D., Chicago
Associate in Medicine, Northwestern University Medical School

9:30 a.m. "Allergic Bronchitis vs. Infective Bronchial Asthma"
Robert J. Becker, M.D., Joliet
Instructor in Medicine, Northwestern University Medical School

9:50 a.m. "The Relationship of Allergy to Collagen Diseases"
William B. Sherman, M.D., New York
Associate Clinical Professor in Medicine, Columbia University; Attending Physician, Roosevelt Hospital; Associate Attending Physician, Presbyterian Hospital.

10:45 a.m. "Drug Reactions on the Hemopoetic System"
Aaron Josephson, M.D., Chicago
Director, Department of Hematologic Research, Michael Reese Hospital; Assistant Professor in Medicine, Chicago Medical School; Consultant—Hematology, West Side V.A. Hospital.

11:15 a.m. Business Meeting of Allergy Section

11:30 a.m. Adjournment to view exhibits

Section on Pathology

Chairman ..... Franklin J. Moore, Chicago
Secretary ..... J. Robert Thompson, Chicago

Friday Morning, May 27
Crystal Room

(Joint Meeting with Illinois Society of Pathologists)

Presiding: Franklin J. Moore, Pathologist, Little Company of Mary Hospital, Chicago

SYMPOSIUM ON ACID-BASE BALANCE

9:00 a.m. CO_2 Determinations
Harry F. Weisberg
Clinical Associate Professor of Medicine, Chicago Medical School

9:30 a.m. Blood pH Determinations
Raymond S. Gambino
Assistant Professor of Pathology, Marquette University

10:00 a.m. Recess

10:15 a.m. Demonstration and Question Period
Raymond S. Gambino

10:45 a.m. Clinical and Laboratory Aspects
William S. Hoffman
Professorial Lecturer in Medicine, University of Illinois

11:15 a.m. Pediatric Aspects
Joseph D. Boggs
Assistant Professor of Pathology, Northwestern University

11:45 a.m. Questions

12:00 noon Luncheon and Business Meeting of Illinois Society of Pathologists
Old Chicago Room, 101

Physicians' Association
Department of Public Welfare
State of Illinois

THURSDAY MORNING, MAY 26
Room 107

10:00 a.m. "Trifluoperazine (Stelazine) in the Treatment of Withdrawn Catatonics"
Rochus Stiller, Elgin
Jacob Glotzer, Elgin
The Elgin State Hospital

"A study of the Effect of a Low Dosage Phenothiazine Drug (Prolixin) on Severely Disturbed (Psychotic Patients"
Anthony Zocchi, Galesburg
Galesburg State Research Hospital

"Experiences Encountered in Establishing a Special Type Alcoholic Treatment Program at the Peoria State Hospital"
William Becker, Peoria
Peoria State Hospital

Adjournment at 11:45 a.m.

Illinois Association of Blood Banks
FRIDAY AFTERNOON, May 28
Crystal Room

Presiding: Paul A. Van Pernis,
Director of Pathology, Swedish-American Hospital, Rockford

2:00 p.m. Transfusion Reactions and the Use of Blood Fractions

4:00 p.m. Business Meeting of Illinois Ass'n. of Blood Banks

Woman's Auxiliary To Illinois State Medical Society

Annual Convention

Hotel Sherman, Chicago, May 23-26
Convention Chairman: Mrs. Sherman C. Arnold

TUESDAY, May 24

10:00 a.m. Formal opening
Mrs. John van Prohaska
Invocation
The Rt. Rev. Msgr.
A. L. Memmesheimer
Pledge to the Flag
Mrs. Robert Dunlevy
Pledge of Loyalty
Mrs. James P. Simonds
Welcome
Mrs. Charles W. Stigman
Response
Mrs. Raymond R. Simpson
Report of Credential and Registration Committee, reading of convention rules of order, adoption of convention program, announcements, appointments of committees.
Greetings from I.S.M.S.
Ralph N. Redmond, M.D.

12:30 p.m. Les Dames Aux Chapeaux Luncheon
Presiding, Mrs. John van Prohaska
Chairman, Mrs. Herbert P. Friedman
Commentator, Mrs. Herbert P. Swartz

WEDNESDAY, May 25

8:10 to
9:15 a.m. Continental breakfast honoring county presidents

9:30 a.m. Round Tables
(1) Presidents and President-Elects; (2) Publications; (3) Community Service and Legislation; (4) Mental Health and Recruitment; (5) A.M.E.F. and Benevolence.

10:30 a.m. Assembly
Presentation of budget, recorders, reference committees reports
Introduction of speaker
Mrs. John van Prohaska
"Frontiers in Religion and Medicine"
Dr. Granger Westberg
Memorial Service

6:00 p.m. Hospitality Hour

7:00 p.m. Annual Dinner
(Speaker to be announced)

THURSDAY, May 26

9:00 a.m. Assembly
Reports of Committees: presentation of budget; election of officers and delegates; new business, convention announcements.

1:00 p.m. Installation Luncheon
(Honoring Mrs. John van Prohaska, retiring president, and Mrs. Charles L. Wunsch, incoming president.)
Installation of officers
"Prairie Tales of Illinois"
Miss Dorothy Posey, Dramatist

3:00 p.m. Post Convention Board Meeting
Press and Publicity Chairman:
Mrs. M. M. Hipskind

Illinois Surgical Society

Monday, May 23, Chicago

8 a.m. Surgical Clinics at Cook County Hospital, Seventh Floor
Karl A. Meyer, M.D., Chairman of Surgical Symposium

Vagotomy and Its Place in the Treatment of Duodenal Ulcer and a Discussion of the Merit of Various Surgical Procedure
Karl A. Meyer, M.D.
Discussion: Charles B. Puestow, M.D., Peter A. Rosi, M.D., Irving F. Stein, M. D.

Indication for the Medical Management of Gastric Ulcer
Frederick Steigmann, M.D.
Discussion: Chester C. Guy, M.D., Kenneth H. Schnepp, M.D., Everett P. Coleman, M.D.

Surgical Management of Cerebral Vascular Insufficiency
Hushang Javid, M.D., Ormand C. Julian, M.D.
Discussion: Harold C. Voris, M.D., Milton Weinberg, M.D.

Indication and use of Arteriography
Geza de Takats, M.D.
Discussion: John L. Keeley, M.D., Robert A. De Bord, M.D.

Malignant Melanoma — Clinical Presentation of Cases and Discussion
George T. Pack, M.D., New York

Injuries to the Hand
William H. Requarth, M.D.
Discussion: John H. Schneewind, M.D., William Johnson, M.D., David A. Bennett, M.D.

Fractures and Trauma
James J. Callahan, M.D.

Surgical Treatment of Diseases of the Thoracic Cavity
George W. Holmes, M.D.
Discussion: Jerome R. Head, M.D., Hiram T. Langston, M.D., W. James Gillesby, M.D., Ward H. Eastman, M.D., John J. Graham, M.D., Robert E. Bowen, M.D.

Ulcerative Colitis-Surgical Management
John B. O'Donoghue, M.D.
Discussion: Everett E. Nicholas, M.D., Charles E. Baldree, M.D.

Vaginal Hysterectomy with Repair of Perineum
Abraham F. Lash, M.D.
Discussion: Charles W. Christie, M.D., Clement P. O'Neill, M.D.

Surgical Management of Carcinoma of the Ovary
Walter J. Reich, M.D.
Discussion: Robert L. Schmitz, M.D., Mitchell Nechtow, M.D.

Surgical Treatment of Benign and Malignant Tumors of the Breast
Louis P. River, M.D.
Discussion: Joseph Silverstein, M.D., Joseph E. Bellas, M.D.

Cause and Treatment for Recurrent Hernia in the Groin
William M. McMillan, M.D.
Discussion: Clifford L. Carter, M.D., Cornelius M. Annan, M.D.

Cholecystectomy and a Discussion of Surgery of the Biliary Tract in Aged
E. Lee Strohl, M.D.
Discussion: Tilden C. Everson, M.D., Kent W. Barber, M.D.

Surgery for Carcinoma of the Thyroid Gland
Arkell M. Vaughn, M.D.
Discussion: Howard P. Sloan, M.D., Richard P. Caddick, M.D.

Surgical Management of Acute Intestinal Obstruction
Nicholas J. Capos, M.D.
Discussion: J. C. Thomas Rogers, M.D., John W. Howser, M.D., Robert J. Freeark, M.D.

Gastrectomy — The Preoperative Preparation
Manuel E. Lichtenstein, M.D.
Discussion: Burton C. Kilbourne, M.D., Willam Rose, M.D., Morris T. Friedell, M.D.

Arterial Transplantation, Endarterectomy for Femoral Occlusion
Richard H. Lawler, M.D.
Discussion: James W. West, M.D., Richard F. Murphy, M.D.

Unusual Surgical Cases
Paul B. Szantos, M.D.
Discussion: Gilbert W. Douglas, M.D., Arthur D. Poppens, M.D.

8 p.m. Scientific Meeting at the University Club
George T. Pack, M.D., New York: "Clinical Aspect of Carcinoma Suspectibility and Carcinoma Immunity."

Members of the medical profession are invited.

ANNOUNCEMENTS



Reunion dinner

The annual medical faculty-alumni reunion dinner of Northwestern University Medical School will be held on May 14 at the Furniture Club of America, 666 Lake Shore Drive, Chicago. The social hour will start at 6 p.m., and dinner will be served at 7 p.m. A skit will be presented by the medical students as entertainment at the dinner. Faculty members and alumni are urged to bring their husbands and wives. Reservations at $8.00 per person may be made at the Medical Alumni Office of the school, 303 E. Chicago Ave., Chicago 11, not later than May 11. There will be special tables reserved for the five-year classes beginning with 1905.

Postgraduate course

A postgraduate course dealing with selected subjects in the field of internal medicine will be given by the American College of Physicians June 20-24 in Indianapolis. Sessions, to be held in the Medical Science Building, will emphasize pathological physiology and the mechanisms of disease.

Registration must be made through the Executive Offices of the College, 4200 Pine St., Philadelphia 4. The fee is $60 for members; $80 for nonmembers.

Telecast on GI problems

On Wednesday evening, April 20, at 8 p.m. *Gastrointestinal Problems: Medicine or Surgery?* will be featured in the Grand Rounds closed-circuit telecast that may be viewed in Chicago at the Uptown Theater, 4814 Broadway. The program will be broadcast from Ohio State University College of Medicine, Columbus.

International conference on congenital malformations

The International Conference on Congenital Malformations will be held in London, July 18-22, 1960, under the sponsorship of the National Foundation. Further information may be obtained by writing the secretariat: Mr. Stanley E. Henwood, International Medical Congress, Ltd., 120 Broadway, New York.

Illinois Obstetrical and Gynecological Society

The annual meeting of the Illinois Obstetrical and Gynecological Society will be held Monday, May 23, in the Sherman Hotel. All physicians are invited to attend this scientific session on the day prior to the opening of the annual meeting of the Illinois State Medical Society.

9:00 Business Meeting
10:00 "Some Representation of the First Five-Year Program of Blood Loss and Allied Factors," Dr. Willard Scrivner
10:45 "Management of the Sensitization Problem," Drs. Thomas Wilson and Warren Greenwold
11:15 "Uncommon Lesions of the Cervix," Dr. Charles Galloway
11:45 "Infertility Problems," Dr. Paul VanVerst
12:30 Luncheon (Please make reservation with secretary.)
1:30 "Use of Surital in Obstetric Anesthesia," Dr. James Stotlar
2:00 "Clinical Aspects of Ovarian Tumors," Dr. William Mengert
2:45 Unusual Case Reports, Drs. Alan and Jack Sampson

Clinics for Crippled Children

Twenty-three clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will count eighteen general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical social, and nursing service. There will be two special clinics for children with cardiac conditions, two for children with cerebral palsy, and one for children with rheumatic fever. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child.

May 3 — Pittsfield, Illini Hospital
May 4 — Fairfield, Fairfield Memorial Hospital
May 4 — Hinsdale, Hinsdale Sanitarium
May 5 — Macomb, District Hospital
May 6 — Chicago Heights (Cardiac), St. James Hospital
May 10 — East St. Louis, St. Mary's Hospital
May 10 — Peoria, Children's Hospital
May 11 — Champaign-Urbana, McKinley Hospital
May 11 — Joliet, Silver Cross Hospital
May 12 — DuQuoin, Marshall-Browning Hospital
May 12 — Springfield, St. John's Hospital
May 12 — Sterling, Community General Hospital
May 17 — Alton, Alton Memorial Hospital
May 18 — Aurora, Copley Memorial Hospital
May 18 — Evergreen Park, Little Company of Mary Hospital
May 18 — Rock Island (Cerebral Palsy), Foss Home, 3808 Eighth Avenue
May 19 — Carlinville, Carlinville Area Hospital
May 19 — Elmhurst (Cardiac), Memorial Hospital of DuPage County
May 19 — Rockford, Rockford Memorial Hospital
May 24 — Effingham (Rheumatic Fever), St. Anthony Hospital
May 24 — Peoria, Children's Hospital
May 25 — Springfield (Cerebral Palsy), Memorial Hospital
May 26 — Decatur, Decatur-Macon County Hospital

Epilepsy week May 9-13

The Chicago Neurological Society, in cooperation with the Illinois Epilepsy League will hold clinics on epilepsy and convulsive disorders in the greater metropolitan Chicago area May 9-13, on the following schedule:

May 9, Monday

1-3 p.m. Northwestern University Medical Clinics, Fairbanks and Chicago Avenue
Dr. Alex J. Arieff and Dr. LeRoy Kurth

2-4 p.m. Cook County Hospital—Fantus Clinic, Harrison and Polk Sts.
Dr. Meyer Perlstein and Dr. Harry Elams

May 10, Tuesday

9-12 a.m. Mercy Hospital—Free Dispensary, 2526 S. Calumet St.
Dr. Stanislaw A. Maslanka and Dr. Maurice Stern

10-12 a.m. Illinois Neuropsychiatric Institute, 912 S. Wood Street
Dr. Ernest Haase and Dr. Fred Stamps

10-12 a.m. Presbyterian-St. Luke's—Senn Bldg.—3rd floor
Dr. Roland Mackay and Dr. Donald Layton

2-4 p.m. Mt. Sinai Clinics—4-West
Dr. Sherman Kaplitz and Dr. Ben Lichtenstein

May 11, Wednesday

10-12 a.m. Children's Memorial Hospital, 707 W. Fullerton Ave.
Dr. Sheldon Kamin, Dr. Joel Brumlich and Dr. Michael Vukovich

May 12, Thursday

10-12 a.m. Michael Reese Hospital—Mandel Clinic, 29th and Ellis, Chicago
Dr. I. C. Sherman and Dr. Louis Boshes

1-3 p.m. Northwestern University Medical Clinics, Fairbanks and Chicago Ave.
Dr. Harold Lawn and Dr. LeRoy Kurth

2:30-4 p.m. University of Chicago Medical Clinics—Billings Hospital, 950 E. 59th, Rm. M-137

Dr. Douglas Buchanan, Dr. Joseph Evans, Dr. S. Schulman and Dr. Charles Barlow

May 13, Friday

9-11 a.m. Evanston Community Hospital—Outpatient Clinic
Dr. Meyer Brown and Dr. I. Zivin

9-12 a.m. Cook County Hospital—Fantus Clinic
Dr. Joseph Luhan, Dr. Harold Manfredi and Dr. Robert Tentler

10-12 a.m. Michael Reese Hospital—Mandel Clinic, 29th and Ellis
Pediatrics Epilepsy Clinic—Dr. Norman Dobin

Medical personnel wishing to attend should call the Illinois Epilepsy League, WAbash 2-3934. The particular clinic specified will then be notified.

Lecture in Medicine

Joseph B. Kirsner, M.D.

University of Chicago School of Medicine

Lecture in Surgery

Willis J. Potts, M.D.

Northwestern University Medical School

Rules for authors

Manuscripts should be submitted in duplicate to the Illinois Medical Journal, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4,500 words; briefer if possible.

Footnotes and references should conform to the following style in the order given: Name of author; title of article; name of periodical; with volume, page, month — day of month if weekly — and year. The Illinois Medical Journal does not assume responsibility for the accuracy of references used with scientific articles.

The first page should list the title, the name of the author (or authors), degrees, and any institutional or other credits. The title of the article should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered, and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively, indicating them in the text. Number, indicate the top, and place the author's name on the back of each illustration. Number legends and type them following the main body of the manuscript, not on the illustrations.

Order blanks for reprints will be sent to the author at the time of publication.

Address manuscripts to T. R. Van Dellen, M.D., Editor, Illinois Medical Journal, 360 N. Michigan Ave., Chicago 1, Illinois.

THE P. R. PAGE

John A. Mirt

What is the AMA doing about it?

If a layman asks what is the AMA doing in a positive way to meet the problems that certain factions in Congress insist must be solved by legislation, a brief reply would be:

(1) The AMA promotes the development of sound, realistic programs geared to the special needs of older people. A good example is the plan for those 65 or over announced in February by the Illinois State Medical Society. This was worked out on rccommendations from the AMA House of Delegates.

(2) The AMA advances the development and extension of voluntary health insurance as the best mechanism for paying for medical and hospital care, and studies the economic trends involved in providing medical service.

(3) The AMA encourages dedicated, qualified young people to study medicine and urges the expansion of existing medical schools and creation of new medical schools.

(4) The AMA plays an active role in encouraging basic and long-range research in the medical sciences so that the best health care may be provided.

Thus, the medical profession is meeting the challenge by providing more care for more Americans at a price they can afford to pay.

The physician's role in politics

The physician who fails to be identified with political campaigns is doing a disservice to himself and the medical profession. He stands to see the quality of medical care deteriorate under government administration and to lose his privilege to practice medicine as an individual.

Every physician, in the exercise of his responsibility as a citizen, must take part in partisan politics to see that the right people are voted into office, whether at a local, state, or national level. Thus only can practical politics be raised to the position of dignity that it merits.

Participation means financial as well as vocal support of qualified candidates, especially if the opponents are welfare state minded. We hear many complaints from elected officials that the only time they hear from physicians is when some specific legislative issue inimical or beneficial to their interests is up for consideration.

The AMA, state medical societies, and county medical societies are by law enjoined from participating in partisan politics. The individual physician, however, is free to do as he pleases in that respect. So, if medicine is to fare well in legislative matters then it is up to the members to take an active part in political campaigns.

Charging for telephone calls

Reports are heard occasionally that some physicians are making a nominal, perhaps $1, charge for professional advice given over the telephone. This policy is based on the fact that these phone calls interrupt office visits at an average of about two times per paticnt and are time consuming.

Considering that bookkeeping and mailing costs are involved in such charges, and that the income tax collector gets a substantial share of the remainder, there is little left for the physician adopting this policy. On the other hand, such a practice can affect public relations. It provides the basis for a charge that the medical profession is looking for every possible means to extract money from the public.

The AMA has recognized the evil in this dollar phone call practice. It has recommended through the AMA News that the fees for home and office calls be sufficiently high to compensate for the occasional telephone "visits," the making out of medical reports, and the filling out of insurance forms.

AT THE EDITOR'S DESK



Relatively inexpensive peritoneal dialysis

The benefits of an artificial kidney can be provided in the patient's own room at a reduced cost with a dialyzing solution (Peridial) and a special closed system of infusion and drainage, announces Cutter Laboratories. Interestingly, the peritoneal lining is used as a dialyzing membrane, and wastes in the solution are removed by abdominal catheter. It is said that such complications as peritonitis, drainage difficulties, and electrolyte imbalances have been greatly reduced by the new system.

Loaning blood

It takes 20 to 30 pints of blood to obtain enough platelets for an experiment by Dr. A. J. Marcus at Manhattan V.A. Hospital. He has succeeded in breaking platelets down into at least six phosphatides. Some of these, he finds, promote clotting; others do not. High concentrations of certain phosphatides permit easy bleeding. The application of his research to hemorrhages and thromboses is obvious. Volunters in the hospital loan their blood for an hour before breakfast, get back their red blood cells by transfusion.

Pharmaceuticals

Miradon, (anisindione), a new oral anticoagulant that has been under testing for five years, is reported by Schering to reduce blood coagulability to therapeutic levels within two or three days. It does not build up to dangerous levels on continued use and permits reversible action with vitamin K. Like the coumarins, it depresses production of prothrombin but is said to be more predictable and stable.

Something new has been added to the advertising of tranquilizers. Roche's new Librium is being touted by its PR department as a "psychodynamic drug" — powerful over the causative factors in mental activity, we suppose — that "helps remove the emotional component of somatic disease." But best of all is its "broad spectrum" action which like certain antibiotics is capable of eliminating a wide variety of causative agents. Does this mean mother-in-laws, drunken husbands, financial difficulties, lack of love or perhaps anxiety, tension, frustration, and hate — regardless of the cause. At any rate, the manufacturers claim it does not "cloud consciousness" nor will its use result in "flattening of the personality." It is useful in alcoholism, calms violence among prisoners, and peps up some chronically depressed patients.

Thiosulfil Forte (sulfamethizole — .5 grams in each tablet) is being introduced by Ayerst Laboratories. It reportedly provides high urinary levels of free sulfa — up to 77.4 per cent within eight hours — has a rapid excretion rate and high solubility. Mild toxic reactions were noted in 1.4 per cent of 3,600 patients receiving the drug.

So long as the kids like it?

The Beech-Nut Company, among one of the firms that cook the baby's dinner, has concocted "a new line of strained and junior beef, lamb, and chicken dinners," each with egg yolk and non-fat dry milk added to boost basic protein ingredients 31 per cent. They report babies clearly enjoy "the mild but distinctive beef, chicken, or lamb flavor, the smooth texture, and appetizing color."

Our pet peeves of the month

The physician who insists on the government maintaining the doctor-patient relationship but regularly neglects to perform his role as doctor in this combine. This should be kept in mind

whenever you are consulted — over the phone, in the office, and in the hospital. No one will ever vote for a change in the way we practice medicine if he loves and respects his physician. This is public relations at the grass root level, and our survival depends upon it.

Agents who sell health insurance using deliberate deception as to the benefits. They claim that the price tag for an appendectomy as listed on the policy is total payment. They neglect to tell the client that the physician sets his own fees and insurance company benefits represent an independent settlement to the insured. The physician does not work for the insurance company and is under no contract to the organization. On the other hand, he is happy when his patients have insurance because it removes part of the financial burden that exists.

Tying them up

It is difficult to describe a technical procedure in layman's language. A recent news release on an article by Dr. Edward A. Kitlowski in the March Journal of the International College of Surgeons serves as an example. This Baltimore plastic surgeon uses a strip of tensor fascia lata to correct ptosis of the eyelid. According to the release that gets in your newspaper: Droopy eyelids are best corrected by tying them to muscles in the forehead. The "thread" is taken from the tissue layer sheathing the thigh muscles and put through the eye of a sharp-edged surgical needle.

Plague still with us

Plague, the scourge of the Middle Ages, still appears on our globe. The World Health Organization reports that there were 300 cases of the human variety in 1959, four of them in California and New Mexico. Eighty-five cases occurred in South America; all were confined to certain areas, however. "Black death" during the fourteenth century is said to have carried off 25 millions (one-fourth the population) in Europe alone.

In pursuit of the estimates

The National Tuberculosis Association, by way of emphasizing the need to step up its campaign against the disease, estimates that at least 250,000 cases of active tuberculosis exist in the United States; it does not know, however, where 100,000 of these estimated cases are. Further, the association says 550,000 Americans are believed to have tuberculosis in an inactive form. No figures on how many of these are known either.

What's in a pill?

An editorial in the New Physician for March, official journal of the Student American Medical Association, made a pointed statement regarding the cost of drugs. Congress is misdirecting its efforts toward what people are paying for, rather than what they are getting from, modern "miracle" medications, it said; the price of a pill includes the cost of measuring the safety and efficiency of that pill in the private doctor's office.

Two-way stretch finds holes in linen

The problem of finding "invisible" pinholes that permit passage of bacteria through hospital operating and delivery room linens appears to have been solved with the development of a strong light over which the linen is stretched. The unit is supplied by National Cylinder Gas Division of Chemetron Corporation, Chicago.

Sometimes "the chicken" comes first

Failure to discipline children consistently is the most frequent problem found among mothers seeking guidance for the Institute for Juvenile Research in Chicago, according to Dr. M. J. Rosenthal. "Treating the mother to rid her of guilt feelings born of equating discipline with hostility," he says, "often produces dramatic improvement."

Flavor and chop suey

Well, they-re improving the flavor of "enriched parboiled rice" by the addition of butylated hydroxytoluene to retard rancidity. All this and the blessing of the Food and Drug Administration too.

Saving a thousand words

A new exhibit at the Museum of Science and Industry relative to the cardiovascular system is worth investigating. Many patients will profit from these displays, particularly those who have heart ailments and thirst for details of their condition. The display is authoritative and up-to-date, and each display will undoubtedly save the physician a thousand words of explanation.

NEWS of the STATE



County
Cook

Chicago Societies. Chicago Diabetes Association re-elected the following officers for terms expiring in February, 1961: Drs. James B. Hurd, president; M. David Allweiss, first vice president; R. Lincoln Kesler, second vice president; and Ralph E. Dolkart, secretary.

The program at the March meeting of the Chicago Society for Internal Medicine was "Hemodialysis in the Treatment of Severe Dilution Hyponatremia," Frank del Greco; "The Effect of 3- (3-OXO-7 Alpha-Acetylthio-17 Beta-hydroxy-4-Androsten-17 Alpha-yl)—Proprionic Acid Lactone (SC-9420, Aldactone) on Edematous Patients," Robert G. Page and A. R. Lavender; and "Chronic Potassium Deficiency and Chronic Pyelonephritis in Man and Animals," Robert C. Muehrcke.

"Some Experiences in a Therapeutic Nursery School — with Emphasis on the Role of the Pediatrician," by Dr. Robert S. Mendelsohn, with discussants Drs. Ann Benjamin and Irene M. Josselyn, was the first topic in a scientific program at the March meeting of the Chicago Pediatric Society. "The Pediatrician in the Community," by Dr. Maya S. Unna, with discussants Drs. Norman T. Welford and John L. Reichert was the second topic.

Chicago Neurological Society at the March meeting heard a discussion on "Unilateral Facial Hyperhidrosis," by Nicholas Wetzel and Sanford J. Larson. At the same meeting under the Dr. Leo A. Kaplan Memorial Lectureship of the Phi Delta Epsilon Foundation, Dr. Erwin W. Straus spoke on "Disturbances of the Body Schema."

Members of the panel of physicians for the symposium on *Abdominal Trauma* sponsored in March by the Metropolitan Chicago Chapter of the American College of Surgeons were Harwell Wilson, chairman, department of surgery, University of Tennessee; Willie R. Roof, surgical department, Baylor University Medical School, Houston; Robert J. Freeark, director of surgical education, Cook County Hospital and associate professor of surgery, Northwestern University Medical School; and Edwin C. Graf, associate in urology, Northwestern University Medical School. The moderator was Dr. Charles B. Puestow, clinical professor of surgery, University of Illinois and chief of surgery, Hines V.A. Hospital.

At the March program of the Chicago Surgical Society papers presented were "Pneumoperitoneum in the Newborn," R. J. Freeark, J. R. Raffensperger, and J. B. Condon; "Colotomy and Coloscopy for Polyps," E. F. Scanlon, J. P. Nesselrod, and S. Soriano, Jr.; "Acute Cecal Diverticulitis," E. E. Nicholas, W. B. Frymark, and J. R. Raffensperger; and "Intra-Atrial Tumors," (with movie), E. H. Fell.

Lectures. The Charles Sumner Bacon Lecture for 1959-60 was delivered at the University of Illinois in March by Dr. Russell R. deAlvarez, executive officer and professor department of obstetrics and gynecology, University of Washington, Seattle, who spoke on "Edema Mechanisms in Normal and Toxemic Pregnancy."

"Management of the Alcoholic and the Drug Addict in the Office," was the subject of a North Shore Hospital lecture in April by Dr. H. H. Garner, chairman and professor of the department of psychiatry and neurology, Chicago Medical School.

Appointments. Dr. Sidney R. Bazell has been named president of the Board of Trustees of the Chicago Medical School Research Foundation.

New Wing. Rest Haven Rehabilitation Hospital has launched a campaign for funds to build a new wing for patient services. The present building was erected in 1950, but this addition will enable the hospital to enlarge its departments of physical, occupational, and speech therapy; also to provide for prevocational workshops and out-patient services.

Europe. Dr. E. L. Compere, chairman, department of orthopedic surgery, Northwestern University Medical School, is among speakers to address the 12th Biennial Congress of the International College of Surgeons, May 15-18, in Rome. Dr. Compere is moderator for the Sport Injuries Section.

Henry

Dr. Jesse C. Lockhart, Peoria, spoke on "Hypertension" at the March meeting of Henry County Medical Society.

Knox

Dr. William J. Grove, associate professor of surgery, University of Illinois College of Medicine, spoke on "Pediatric Surgical Emergencies," at the March meeting of the Knox County Medical Society.

Lake

"Anesthesia — How Dangerous Is It? How Safe Could It Be?" was the subject presented at the March meeting of the Lake County Medical Society by Dr. E. Trier Morch, University of Illinois College of Medicine.

LaSalle

Dr. Edward T. Wilson, clinical associate in urology, Stritch School of Medicine of Loyola University, spoke on "Gross Hematuria," at the March meeting of the LaSalle County Medical Society.

Madison

The March meeting of the Madison County Medical Society was held in East Alton. The business of the meeting included a discussion of the Forand Bill, problem of aging, instructions to delegates, the constitution and bylaws, and other matters.

Marion

Drs. William Daughaday, Glenn Green, and Edward Massie of Washington University, St. Louis, participated in a panel discussion on thyroid disease at the February meeting of the Marion County Medical Society.

Peoria

Dr. Ernest E. Klein, Peoria State Hospital was the speaker at the March meeting of the Peoria Medical Society. His topic was on the movie "As Ye Sow," with a discussion of HB 1278.

Pike-Calhoun

Two polio inoculation clinics were scheduled early in April for Pike county under the auspices of the Pike-Calhoun Medical Society.

Rock Island

Dr. William Gillesby, V.A. Hospital, Hines, spoke on "G.I. Hemorrhage," at the March meeting of the Rock Island County Medical Society.

St. Clair

Meeting. The March meeting of St. Clair County Medical Society was an executive committee meeting.

Public Relations. Dr. M. Eisele, chairman, Public Relations Committee, and members of this committee are surveying the need for all immunization procedures in the county to establish a basis for recommendations to bring any procedure in a given area up to the average standard.

Sangamon

Postgraduate Course. Drs. Ira M. Rosenthal, associate professor of pediatrics; Robert J. Ryan, instructor in medicine; Orville T. Bailey, professor of neurology, all from the University of Illinois College of Medicine, and Dr. Ernest F. Adams, medical director of the Institute of Physical Medicine and Rehabilitation, Peoria, discussed cardiovascular, thyroid, and adrenal problems at the March postgraduate course in Springfield. Dr. William S. Dye, clinical associate professor of surgery at the medical school, was the dinner speaker, reporting on replacements for major blood vessels. Dr. Jacob E. Reisch, a councilor of the state society, spoke that evening on "Current Medical Legislation." The Sangamon County Medical Society was host at the luncheon and dinner. The program presented for mid-Illinois physicians was sponsored by the Committee on Postgraduate Medical Education and Scientific Service of the Illinois State Medical Society. Sixty-five physicians attended.

Vermilion

At the March meeting of the Vermilion County Medical Society Dr. D. M. Jordan, W. M. Myers, and L. A. Pennington, members of the Eastern Illinois Mental Health Unit, spoke on "Use and Abuse of Mental Health Clinics."

Winnebago

At the March 8 meeting of the Winnebago County Medical Society Mr. Leo Brown, director of communications, AMA, spoke on current legislative problems and the basic principles of public relations.

General

International College of Surgeons. Regents and vice regents of the United States Section of the International College of Surgeons held a Chicago dinner business meeting in March. Included on the agenda was a private memorial service for Dr. Max Thorek, founder, secretary general, and editor-in-chief of the College's Journal, and for Dr. Ross T. McIntire, executive director. A public memorial service for Drs. Thorek and McIntire was discussed.

"Your Health Comes First" over Radio Chicago WJJD:

April 27 at 8:45 p.m.—Edson F. Fowler, clinical assistant professor of surgery, University of Illinois College of Medicine, will discuss "Diagnosis of Cancer."

This is a public service program sponsored by the Illinois State Medical Society in cooperation with Radio Chicago WJJD.

Lectures Arranged through the Illinois State Medical Society:

Lawrence B. Holden, Peoria, affiliated with the Methodist and St. Francis Hospitals and member of the Interurban Neurosurgical Society, addressed the Bureau County Medical Society in Spring Valley March 8 on "The Fundamentals of a Neurological Examination."

Max K. Hirschfelder, Centralia, addressed a joint meeting of the Macoupin and Montgomery County Medical Societies in Carlinville March 22 on "New Developments in Ophthalmology of Interest and Importance to the General Practitioner."

A. Edward Livingston, Bloomington, will address the Logan County Medical Society in Lincoln, April 21, on "The Tension State, Organic and Functional." Jordan M. Scher, assistant professor of neurology and psychiatry, Northwestern University Medical School, will present the last lecture in this series of psychiatric programs in Lincoln May 19 on "All are Daft but thee and me, but betimes . . . "

Frederick Stenn, assistant professor of medicine, Northwestern University Medical School, will address the Peck School Parent-Teacher Association in Chicago May 11 on "Health and Happiness.'

Irvin H. Strub, clinical associate, Department of Medicine, Stritch School of Medicine of Loyola University, will address a joint meeting of the Whiteside and Lee County Medical Societies in Sterling May 19 on "Common Diseases of the Small Bowel."

Henry T. Ricketts, professor of medicine, University of Chicago School of Medicine, will address the Stock Yards Branch of the Chicago Medical Society May 20 on "Management of Diabetes and Its Sequelae."

Palmer W. Good, associate attending ophthalmologist at Childrens' Memorial Hospital, will address the Zion Lutheran School Parent-Teacher Association in Hinsdale May 24 on "Care of the Eyes of the Grammar School Child."

Making a travesty of the law. The Radiation Control Act, approved in July last year by the Illinois Legislature, provides that "no person shall intentionally administer radiation to a human being unless such person is licensed to practice a treatment or human ailments by virtue of the Illinois Medical, Dental, or Chiropody Practice Acts, or as technician, nurse, or other assistant, is acting under the supervision, prescription, or direction of such licensed person."

In the opinion of the members of the Chicago Roentgen Society, use of shoe-fitting fluoroscopes is not necessary for the proper fitting of shoes and is dangerous to the public health. Therefore, it believes that any member of the medical, dental, or chiropody professions who allows the use of a shoe-fitting fluoroscope under his supervision is making a travesty of the Radiation Control Act and is defeating its purpose.

Deaths

Frederick Michael Blome*, Champaign, who graduated at National Medical University, Chicago, in 1906, died December 3, aged 79.

Franklin Theodore Brenner*, Quincy, who graduated at Rush Medical College in 1895, died November 12, aged 88. He was a Fellow of the American College of Surgeons, and served many years on the staffs of the Blessing Hospital and St. Mary's Hospital.

Wayland E. Campbell*, Arlington Heights, who graduated at the University of Arkansas School of Medicine, Little Rock, in 1944, died November 9, aged 46. He was a veteran of World War II, and served on the staffs of Sherman and St. Joseph's Hospitals in Elgin.

Ernst Cronheim*, Chicago, who graduated at Friedrich-Wilhelms-Universitat Medizinsche Facultat, Berlin, in 1923, died February 6, aged 61. He had been on the staffs of Weiss Memorial and American Hospitals.

Joseph L. Cunningham*, retired, Chicago, who graduated at the University of Illinois College of Medicine in 1907, died February 25, aged 81. He had been chief of staff at John B. Murphy Hospital and staff physician at Frank Cuneo Memorial and Columbus Hospitals.

Charles Henry Dehm, Middlegrove, who graduated at the College of Physicians and Surgeons, Keokuk, Iowa, in 1897, died November 9, aged 91.

George M. De Young*, Peoria, who graduated at Rush Medical College in 1932, died February 27, aged 56.

Clyde L. Drennan*, Polo, who graduated at Northwestern University Medical School in 1937, died December 18, aged 58.

George P. Gavaris*, Chicago, who graduated at Universitat Basel Medizinische Fakultat, Switzerland, in 1907, died February 9, aged 74. He was a staff member of Columbus, Grant, St. Joseph's, and American Hospitals.

Lyndon D. Harris*, Chicago, who graduated at University of Illinois College of Medicine in 1912, died February 15, aged 71. He was a member of the American Academy of General Practice.

Bruce A. Harrison*, Colchester, who graduated at the University of Illinois College of Medicine in 1909, died February 3, aged 74.

Irving I. Ludwig*, retired, Chicago, who graduated at Loyola University School of Medicine in 1930, died February 15, aged 55. He had been psychiatrist for the Veterans Administration in Chicago, but died in Mexico City where he moved three years ago.

William R. Marshall*, Clinton, who graduated at Chicago College of Medicine and Surgery in 1909, died December 11, aged 85.

Millard F. Norris, Jr.*, Springfield, who graduated at Chicago Medical School in 1934, died February 13, aged 52.

Alex B. Ragins*, Chicago, who graduated at University of Illinois College of Medicine in 1932, died February 14, aged 52. We was a pathologist at Cook County Hospital.

Anthony Kazis Rutkauskas, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1906, died September 29, aged 84. He was a veteran of the Spanish-American War.

Tom D. Spies, Birmingham, Alabama, who graduated at Harvard Medical School, Boston, in 1928, died February 28, aged 57. He was C. F. Kettering professor of nutrition and metabolism and chairman of the department at Northwestern University Medical School, Chicago; and scientific director of the Nutrition Clinic, Hillman Hospital, Birmingham. Dr. Spies was first to use synthetic folic acid in the treatment of anemic diseases; to use thiamin for treating deficiency diseases, and to prove that niacin could cure within a few hours even violent insanity caused by malnutrition. The Distinguished Service Award of the American Medical Association was presented to him in 1957 for "his part in wiping out the curse of pellagra from our South and deadly tropical anemias from Cuba and Puerto Rico."

Frank B. Van Wormer*, Mechanicsburg, who graduated at Milwaukee Medical College in 1912, died February 17, aged 72.

Paul K. Weichselbaum*, Chicago, who graduated at the University of Illinois College of Medicine in 1938, died February 19, aged 46. He was on the staffs of Grant and University of Illinois Hospitals, and was a diplomate of the American Board of Dermatology.

Ralph G. Whitmer*, Sterling, who graduated at Rush Medical College in 1927, died November 12, aged 71.

*Indicates member of the Illinois State Medical Society.

Reports of Officers and Committees

for the

1960 ANNUAL MEETING ISMS

THE 1960 HOUSE OF DELEGATES

Officers

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President Elect .....H. Close Hesseltine, Chicago
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Second Vice President .Allison L. Burdick, Chicago
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Second District . .Ralph N. Redmond, Sterling
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Caesar Portes, Chicago
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Carl F. Steinhoff — C. Paul White
H. Kenneth Scatliff — Burtis E. Montgomery
Walter C. Bornemeier — Arthur F. Goodyear
Frank H. Fowler — Harlan English
Joseph T. O'Neill

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Percy E. Hopkins — Harry M. Hedge
C. Paul White — Leo P. A. Sweeney
Willis I. Lewis — Arkell M. Vaughn
F. Lee Stone — F. Garm Norbury
Lester S. Reavley

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C. L. Weber — Lewis Ent
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Max Fraenkel — H. E. Tarpley
BOONE
John Steinkamp — Paul Dommers
BUREAU
Julius M. Kowalski — Karl M. Nelson
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E. C. Turner — L. B. Hussey
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B. A. Desulis — C. H. Potts
CHAMPAIGN
W. H. Schowengerdt — Hans Buley
C. H. Walton — Wm. McLane
CHRISTIAN
Ralph M. Seaton — R. J. Mathewson
CLARK
Eugene P. Johnson — George T. Mitchell
CLAY
L. L. Hutchins — M. H. Parker
CLINTON
F. H. Ketterer — W. R. Ketterer

Coles-Cumberland		
Clinton Swickard	E. N. Zinschlag	
Crawford		
M. O. Miodus	A. L. Lowe	
DeKalb		
William G. Thomas	Otto Keller	
DeWitt		
H. L. Meltzer	D. Sellett	
Douglas		
Harry Messmore, Jr.	Philip F. Deaver	
DuPage		
Joseph R. O'Donnell	Armand Mauzey	
Norton R. Groth	A. P. LeBeau	
I. E. Bartlett	C. B. VanGorder	
Edgar		
Gordon H. Sprague	Waldemar Hoeffding	
Edwards		
P. S. Nierenberg	Willam J. Dechler	
Effingham		
Henry Thompson	B. A. Samp	
Fayette		
Joshua H. Weiner	Miller Greer	
Ford		
Paul W. Sunderland	E. C. Bucher	
Franklin		
Basil A. Moskoff	Louis E. Cowsert	
Fulton		
Paul D. Reinertsen	Keith H. Frankhauser	
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J. A. Kirby	Joe Bryant	
Greene		
Paul A. Dailey	A. K. Baldwin	
Hancock		
C. W. Bruehsel	B. T. Mueller	
Henderson		
Henry		
A. W. Wellstein	Paul M. Schmidt	
Iroquois		
John R. Schlereth	R. Kent Swedlund	
Jackson		
W. D. Mohlenbrock	Charles W. Young	
Jasper		
C. O. Absher	D. L. Hartrich	
Jefferson-Hamilton		
C. K. Wells	Andy Hall	
Jersey		
W. Clark Doak	H. E. Wuestenfeld	
JoDaviess		
C. George Ward	William G. Gillies	
Johnson		
A. E. Veach	W. J. Wakefield	
Kane		
J. D. Milligan	John A. Newkirk	
B. F. Shirer	John M. Abell	
P. T. Dolan	J. L. Bordenave	
Kankakee		
Edward L. Hayes	A. A. Palow	
Kendall		
M. R. Saxon	R. C. Crawford	
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Lake		
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George B. Callahan	Charles Culmer	
C. O. Edwards	M. J. McAndrew	
La Salle		
William Scanlon	J. B. Aplington	
Lawrence		
Tom Kirkwood	Charles G. Stoll	
Lee		
Charles LeSage	Samuel Adler	
Livingston		
Leslie Lowenthal	Paul A. Gannon	
Logan		
Frank Hagans	Charles R. Bardwell	
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C. Elliott Bell	C. F. Downing	
Maurice D. Murfin	H. J. Burstein	
Macoupin		
Joseph J. Grandone	Donald L. Grieme	
Madison		
Eugene F. Moore	B. B. Berman	
Harry Mantz	E. K. DuVivier	
Marion		
Edward F. Stephens	Max Hirschfelder	
Mason		
Jack Gibbs	Donald Stehr	
Massac		
Virgil O. Decker		
McDonough		
V. B. Adams	R. F. Millet	
McHenry		
Mladen Mijanovich	John R. Tambone	
McLean		
G. E. Hartenbower	Ray W. Doud	
Menard		
H. K. Moulton	Stanley Paulauskis	
Mercer		
Martin Conway	John E. Bohan	
Monroe		
Joseph A. Werth	Russel W. Jost	
Montgomery		
	Clifford Draper	

Morgan	
Albert F. Fricke	Robert R. Hartman
Moultrie	
Dale W. VandenBrink	Eugene Joseph Boros
Ogle	
A. R. Bogue	Clyde L. Drennan
Peoria	
Norman Powers	Willard Easton
William Hart	Edward Ward
Carl E. Sibilsky	Clinton S. Koerner
Perry	
R. T. Matlavish	C. E. Cawvey
Piatt	
Pike-Calhoun	
James H. Rutledge	James E. Goodman
Pulaski	
George J. Meshew	Burton E. Bagby
Randolph	
R. E. Schettler	G. C. Mayfield
Richland	
William A. Moore	Raymond B. Murphy
Rock Island	
J. G. Gustafson	John Roane
C. A. Costigan	L. S. Helfrich
Saint Clair	
William H. Walton	Howard L. Lange
E. W. Cannady	V. P. Siegel
Saline	
N. A. Thompson	D. A. Lehman
Sangamon	
Darrell H. Trumpe	Marvin Salzman
Thomas F. Harmon	William DeHollander
Greshom Greening	Emmet F. Pearson
Schuyler	
Henry C. Zingher	
Shelby	
Elvin Clark	H. H. Pettry
Stephenson	
L. F. Rockey	Warren C. Mills
Tazewell	
Lawrence Rossi	William B. Werner
Union	
William H. Whiting	C. D. Nobles
Vermilion	
Jean W. Moore	Donald D. Spicer
Wabash	
T. R. Young	C. L. Johns
Warren	
James W. Marshall	R. E. Icenogle
Washington	
Walter P. Plassman	William P. Lesko
Wayne	
S. W. Konarski	Edward S. Talaga
White	
William Courtnage	Stanley B. Abelson
Whiteside	
Clarence J. Mueller	
Will Grundy	
Leonard F. Roblee	Elmer A. Albers
Nicholas P. Primiano	Perry G. Pratt
Williamson	
John W. Tidwell	H. A. Merrel
Winnebago	
Norman L. Sheehe	J. M. Severson, Jr.
William K. Ford	M. L. Duchon
Robert E. Heerens	C. W. Fredberg
Woodford	
H. T. Barrett	R. S. Davies

Corrections in this list should be sent to the Office of the Secretary, 224 South Main Street, Monmouth, at once.

Chicago Medical Society

Aux Plaines Branch	
Delegates:	Alternates:
John Hyde	Allen R. Morrison
C. Otis Smith	P. E. Cocagne
Fred L. Glenn	Paul F. Fox
Charles Weigel	Michael J. Parneti
Arthur Joslyn, Sr.	Martin W. Green
Louis Plzak	Harold E. Smith
Joseph Sodaro	George A. Barnett
Robert French	Harry H. Stephens
Calumet Branch	
Paul Blackburn	Arthur Rink
Norman Meyer	Leonard P. Brodt
Warren W. Young	William Orcutt
Douglas Park Branch	
John C. Smith	Rudolph C. Mrazek
L. S. Tichy	Raymond Nemecek
Edward Palmer	N. R. Frankovelgia
John D. McCarthy	Norman Frank
Englewood Branch	
A. J. Sullivan	James Griffin
John C. Wall	John E. Meyer
Francis W. Young	Joseph Patka
Frank Kwinn	Alfred C. Wendt
William Nainis	George Rukstinat
North Suburban Branch	
Edson F. Fowler	William H. Harridge
Herbert S. Miller	William G. Cummings
Noel G. Shaw	Frank W. Pirruccello
Raymond H. Conley	Jerome T. Paul

Robert A. Snyder	Donald E. Hansen
Harold C. Lueth	Warren C. Jenkins
C. Malcolm Rice	Paul L. Bedinger
John L. Savage	Luella E. Nadelhoffer
Irving Park Suburban Branch	
George W. Holmes	Arnold U. Derman
F. A. Tworoger	S. A. Franzblau
H. L. Wallin	Otto L. Bettag
Eugene Narsete	H. P. Carstens
A. N. Ruggie	Allen Hrejsa
L. F. Mammoser	George Pastnack
Jackson Park Branch	
William J. Hand	C. P. McCartney
A. J. Brislen	Richard Landau
Wright Adams	M. M. Hipskind
Frank F. Maple	Chester Guy
Josiah J. Moore	Julius Ginsberg
O. W. Rest	Harry Hunter
Frederick W. Slobe	Danial J. Pachman
North Shore Branch	
J. Ernest Breed	Ralph Lidge
Walter Hammond	Philip McGuire
Edward C. Helfers	Irving Perrill
W. B. Stromberg	Russell Elmer
Karl L. Vehe	Chester Crean
Joseph DeCaro	Paul Vermeren
W. O. Ackley	Harry V. Carter
George H. Irwin	A. P. Sandahl
Kenneth C. Johnston	B. J. Soboroff
C. A. Norberg	Robert Anderson
J. S. Schriver	James Fink
North Side Branch	
G. L. Kaufmann	Samuel Levinson
John R. Wolff	B. F. Launsbury
Jack Williams	Clifton Reeder
James Cross	Leander Riba
Michael Boley	Coye C. Mason
Henri DuVries	Roland R. Cross, Jr.
S. L. Andelman	Vincent C. Freda
William Hutchison	David Slight
Northwest Branch	
N. J. Kupferberg	Louis Wajay
M. J. Kutza	Peter Furno
A. J. Linowiecki	James M. McDonnough
F. M. Nicholson	L. S. Sluzynski
M. A. Rydelski	O. W. Konzelman
S. M. Goldberger	Matthew Uznanski
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Casper M. Epsteen	John Marlowe
Carl Werelius	Raymond White
South Side Branch	
Quentin Young	Jacob Epstein
Robert R. Mustell	Maurice Gleason
Southern Cook County Branch	
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Herbert Jansen	C. Dale Collins
Stock Yards Branch	
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West Side Branch	
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Nicholas Balsamo	Lawrence Ryan
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Ted LeBoy	Vida V. Marzano
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Karl A. Meyer	
Norris J. Heckel	
Edwin F. Hirsch	
George C. Turner	
Theodore R. VanDellen	
Patrick H. McNulty	

MEETINGS OF THE HOUSE OF DELEGATES, 1960

Agenda

FIRST MEETING—MONDAY EVENING,
MAY 23, 1960
LOUIS XVI ROOM—8:00 P.M.

1. Call to order by the president — Joseph T. O'Neill
2. Report of the Committee on Credentials
3. Roll call by the secretary — George F. Lull
4. Presentation of Outstanding General Practitioner Award
   To: John Colville Smith of Chicago
   By: The president, Joseph T. O'Neill
5. Approval of minutes of May 1959 meetings as published in a supplement to the Illinois Medical Journal
   Approval of minutes of special meeting December 12, 13, 1959, as published in the Illinois Medical Journal
6. Appointment of reference committees by the president
7. Consideration of annual reports as published in the handbook—with supplementary reports as desired

8. Unfinished business
9. New business
   a. Introduction of resolutions and referring of same to proper reference committees
   b. Other new business
10. Adjournment

SECOND MEETING—WEDNESDAY MORNING, MAY 25, 1960 LOUIS XVI ROOM—8:30 A.M.

1. Call to order by the president — Joseph T. O'Neill
2. Report of the Committee on Credentials
3. Roll call by the secretary — George F. Lull
4. Reading and approval of minutes of previous session
5. Selection of meeting place for 1963 annual meeting
6. Reports of reference committees and action on same
7. Unfinished business
8. New business
   a. Communications
   b. Election of Emeritus members
   c. Election of Retired members
   d. Other new business
9. Adjournment

THIRD MEETING—THURSDAY MORNING, MAY 26, 1960 LOUIS XVI ROOM—9:00 A.M.

1. Call to order by the president — Joseph T. O'Neill
2. Report of the Committee on Credentials
3. Roll call by the secretary — George F. Lull
4. Reading and approval of minutes of previous session
5. Announcement of awards to Scientific Exhibitors — Coye C. Mason, Chairman and Director of Scientific Exhibits
6. Election of Officers
   a. President Elect (downstate) for a term of two years.
   b. First Vice President (Chicago Medical Society)
   c. Second Vice President (downstate)
   d. Secretary-Treasurer
7. Election of Councilors

District	*Term expiring*
Third	Harry J. Dooley
	Earl H. Blair
Sixth	Newton DuPuy
Ninth	Burtis E. Montgomery
Tenth	Willard W. Fullerton

8. Election of Delegates to the American Medical Association
   To take office on January 1, 1961 and serve for a term of two years.
   Term expiring on December 31, 1960:
   Percy E. Hopkins
   Leo P. A. Sweeney
   Burtis E. Montgomery
9. Election of Alternate Delegates to the American Medical Association
   To take office on January 1, 1961 and serve for a term of two years. Term expiring on December 31, 1960:
   Maurice M. Hoeltgen
   Allison L. Burdick
   Norris J. Heckel
   Harry Mantz
   Lester S. Reavley
10. Election of members of Standing (Constitutional) Committees
    a. Grievance Committee — Two members elected each year for a three year term.
    Terms expiring:
    Percy E. Hopkins, Chicago
    Victor V. Rockey, Freeport
    b. Committee on Medical Education and Hospitals: Three members elected each year for a 1-year term.
    Terms expiring:
    Kenneth C. Johnston, Chairman, Chicago
    Ward Eastman, Peoria
    George F. O'Brien, Chicago
    c. Medico Legal Committee — Two members elected each year for a three year term
    Terms expiring:
    George C. Turner, Chairman, Chicago
    Charles Allison, Kankakee
    d. Committee on Medical Testimony — Two members elected each year for a four year term
    Terms expiring:
    Leo P. A. Sweeney, Chairman, Chicago
    Harry D. Nesmith, Salem

e. Committee on Prepayment Plans and Organizations — One member elected each year for a three year term

Term expiring:

E. Lee Strohl, Chairman, Chicago

f. Committee on Medical Benevolence — One elected each year for a three year term

Term expiring:

F. M. Nicholson, Chicago

11. Fixing of per capita assessment for 1961
12. Any additional reports of reference committees not presented at the second meeting of the House held on Wednesday
13. Unfinished business
14. New business
15. Induction of president elect, H. Close Hesseltine, into the office of president of the Illinois State Medical Society by the retiring president, Joseph T. O'Neill
16. Adjournment, sine die

COMMITTEES

FOR 1960 HOUSE OF DELEGATES

Credentials

Louis XVI Room:

(1) Monday, May 23, 7:30 p.m.
(2) Wednesday, May 25, 8:00 a.m.
(3) Thursday, May 26, 8:30 a.m.

Carl E. Sibilsky, Chairman	Peoria
Lawrence F. Rockey	Stephenson County
Elmer V. McCarthy	South Chicago Branch
Joseph F. O'Malley	West Side Branch

Attendance

This committee will distribute and collect attendance slips,
voting slips
act as Sergeants at Arms if necessary

Distribute mimeo material to the House as prepared by secretary's office during meeting.

Andrew J. Sullivan, Chairman	Englewood Branch Society	Chicago
Michael Kutza	Northwest Branch Society	Chicago
Edwin J. Lukaszewski	Stock Yards Branch Society	Chicago
Henry Thompson	Effingham County Medical	Society
Jean W. Moore	Vermilion County Medical	Society

Reference Committee on Reports of Officers, Councilors, Delegates to AMA

Jade Room, Tuesday, May 24, 10:00 a.m.

To report on the reports of:	President President Elect Secretary-Treasurer Chairman of the Council Councilors, 11 Districts Councilor at large Delegates to the AMA
George B. Callahan, Chairman	Lake County Society
William A. Moore	Richland County Society
Patrick H. McNulty	At large
Clarence A. Norberg	North Shore Branch
Lambert F. Mammoser	Irving Park Branch

Reference Committee on Reports of Constitutional Committee and Journal

Polo Room, Tuesday, May 24, 10:00 a.m.

To receive and report on the reports of:

Committee on Archives
Committee on Medical Service & Public Relations
Committee on Medical Education & Hospitals
Medico Legal Committee
Committee on Medical Benevolence
Committee on Medical Testimony
Grievance Committee
Committee on Prepayment Plans & Organizations
Editor — Illinois Medical Journal
Editorial Board
Journal Committee

John R. Wolff, Chairman	North Side Branch
Wright Adams	Jackson Park Branch
Robert E. Heerens	Winnebago County Society
Kenneth H. Keeton	Adams County Society
Clarence H. Walton	Champaign County Society

Reference Committee on Reports of Council Committees No. 1

Life Room, Tuesday, May 24, 10:00 a.m.

To receive and report on the reports of:

Advisory Committee—Dependents Medical Care Program

Advisory Committee—Illinois Public Aid Commission

Advisory Committee—Medical Assistants Association

Advisory Committee—Governmental Medical Services:
- American Legion
- Civil Defense
- Coroner's Committee
- Selective Service
- Veterans Administration

Advisory Committee—Woman's Auxiliary

Report of the President, Woman's Auxiliary

Darrell H. Trumpe, Chairman	Sangamon County Society
Julius M. Kowalski	Christian County Society
Noel G. Shaw	North Suburban Branch
Theodore R. Van Dellen	At large
L. S. Tichy	Douglas Branch

Reference Committee on Reports of Council Committees No. 2

Time Room, Tuesday, May 24, 10:00 a.m.

To receive and report on the reports of:
- Committee on Aging
- Liaison to Illinois Bar Association
- Committee on Birth Certificates
- Committee on Disease Control:
  - Cancer
  - Cardiovascular Disease
  - Mental Health
  - Tuberculosis

Warren W. Young, Chairman	Calumet Branch
Isaac E. Bartlett	DuPage County Society
Charles H. LeSage	Lee County Society
John W. Tidwell	Williamson County Society
C. Otis Smith	Aux Plaines Branch

Reference Committee on Constitution and By-Laws No. 3

Orchid Room, Tuesday, May 24, 10:00 a.m.

To receive and report on the suggested changes in the Constitution and By-Laws

William H. Schowengerdt, Chairman	Champaign County Society
Patrick T. Dolan	Kane County Society
Solomon M. Goldberger	Northwest Branch
Gustav L. Kaufmann	North Side Branch
Fred A. Tworoger	Irving Park Branch
N. A. Thompson	Saline County Society

Reference Committee on Reports of Council Committees No. 4

Holiday Room, Tuesday, May 24, 10:00 a.m.

To receive and report on the reports of the:
- Ethical Relations Committee
- Fifty Year Club Committee
- Committee on Industrial Health
- Committee on Impartial Medical Testimony
- Liaison—Illinois Hospital Association
- Committee on Insurance
- Maternal Welfare Committee
- Committee on Medical Economics
- Committee on Narcotics
- Committee on Necrology

Maurice Murfin, Chairman	Macon County Society
Harry Mantz	Madison County Society
Paul D. Reinertsen	Fulton County Society
Quentin D. Young	South Side Branch
James H. Cross	North Side Branch

Reference Committee on Reports of Council Committees No. 5

Gold Coast Room, Tuesday, May 24, 10:00 a.m.

To receive and report on the reports of:
- Committee on Nursing
- Committee on Nutrition
- Committee on Physically Handicapped Children
- Committee on Polio Control
- Committee on Postgraduate Medical Education and Scientific Service
- Committee on Radiation
- Committee on Rural Health
- Committee on School Health
- Committee on Traffic Safety

and also to report on any other business referred to the Committee by the President

William H. Whiting, Chairman	Union County Society
J. Ernest Breed	North Shore Branch
Joseph Sodaro	Aux Plaines Branch
Samuel J. Sullivan	South Chicago Branch
William H. Walton	St. Clair County Society

REPORT OF THE PRESIDENT

The year began on a rather ominous note not only because of changes to be made in the general structure of our organization, contemplated as a result of the management survey by Roger, Slade, & Hill, but particularly because of the critical illness of our Secretary, Dr. Camp, who had carried the executive load for so many officers and members of the state society for so many years. The evolution of the contemplated changes was necessarily slowed by the uncertainty of Dr. Camp's illness. His death occurred in October, as most of you know. We were extremely fortunate in having Dr. George Lull available to fill in for him, and to have Dr. Van Dellen available for the editorship of the journal. Prior to Dr. Camp's death, all of the officers and many of the councilors had the pleasure of seeing him inducted into the Fifty-Year Club at a meeting of the Warren County Medical Society in Monmouth. We were most fortunate in having this function planned, and being able to pay a last fitting tribute to the man who represented Illinois medicine for so many years. The Foundation, which he so ably helped to establish, was able to go on as he would have liked it to do. May I suggest that you all pay a tribute to Dr. George Lull and Dr. T. R. Van Dellen for so ably filling the gap which the death of Dr. Camp left, and permitting the society to function as smoothly as it has during the past year.

I had the extreme pleasure of attending the annual meeting of the AMA in Atlantic City, also the Interim Session at Dallas. I am greatly impressed with the caliber of the men who represent us at the AMA level. They are well known around the House of Delegates and take their duties seriously and work hard. It was also my good fortune to attend the meeting of the Kentucky Medical Society, in Louisville, in September, and also the meeting of the Michigan State Medical Association, in Grand Rapids, the latter part of September and the first few days of October. Their problems are a great deal like our problems. It was extremely interesting to see the House of Delegates of the Michigan association wrestle with the problem of Blue Shield in some of the various classifications which prevail in that state. I am also looking forward to attending the meeting of the Missouri and the Wisconsin State Medical associations.

The American Medical Association called a Regional Conference of adjacent states which was held in Kansas City the latter part of October. Your president was invited to participate in this conference, held entirely for lay people rather than for doctors. It was extremely interesting to hear the view point of these lay groups and to hear their reactions to the program the AMA and component state associations were trying to develop to help them. I have attended all Council meetings and many of the special meetings of the committees, and have had the pleasure and experience of presiding at the First Interim Session of our own House of Delegates in December. The volume of business which has passed through the Council this year has been very heavy, and one is constantly impressed with the devotion of the councilors to the problems of medicine that confront each one of us.

I wish to express my appreciation to the staff at both the Monmouth and Chicago offices for their willing help during my term of office. There are some subjects about which I would wish to report to you, notably the program for insurance coverage of people over 65 years of age, which programs are in the making, and I shall present these to you in a supplimental report which I will file, so that each delegates might receive a copy of it before the annual meeting in May.

It has been a pleasure to have been your ambassador to many lay organizations and medical associations during this year, and I have done my best to represent you adequately.

Respectfully submitted,

Joseph T. O'Neill, M.D.

REPORT OF THE PRESIDENT-ELECT

This year has been one of pleasure, full of satisfaction by being of service to the full membership. It has been marked with an increasing sense of growing responsibilities in the duties immediately ahead. Your president-elect has made every effort to fulfill promptly and creditably his duties. It was my pleasure to attend, with President O'Neill, the annual meeting of the Michigan State Medical Society last autumn. I served as his representative at the Indiana State Medical Society's fall meeting. With only one exception, your president-elect has attended

all of the Council meetings. During the past months changes became mandatory in our organization — as in all growing and dynamic organizations, changes become mandatory. These changes must yield better service to the members, protect the rights of the public as well as the profession.

Your society is fortunate in the interest and dedication of the members of the House of Delegates. The Council has carried out those matters assigned to it by the Constitution and By-Laws and also by the House of Delegates. The Constitution and By-Laws were set down by this and previous Houses of Delegates. Your society has been blessed with most competent leaders in the president, Dr. Joseph T. O'Neill, and the chairman of the Council, Dr. Burtis E. Montgomery, during one of the critical periods of its life. We lost a most faithful and respected member, our secretary, Dr. Harold M. Camp. Dr. Lull deserves sincere praise for his services as secretary. Both the sagacious, diplomatic, and magnanimous president, Dr. O'Neill, and the impartial, unselfish and brilliant chairman of the Council, Dr. Montgomery, have been most inspirational in decorum, competence and character.

Tradition assures me that I shall have wholehearted support of the House of Delegates and the councilors and officers during the course of the coming year. It is my fond hope that a year hence, as I close my presidential year, I can do so not with credit to myself, but in pride and happiness of the achievements and progress of our society in successfully resolving our problems, especially the ones in the care to our older people and in advancing the standards of medicine. Surely, we can demonstrate our confidence and stability in defeating the unsound and improper social-economic and political attacks.

Respectfully submitted,

H. Close Hesseltine, M.D.

REPORT OF THE SECRETARY-TREASURER

Due to the death of Dr. Harold M. Camp, the society was left without a secretary-treasurer. The Council appointed the undersigned on October 25, 1959, to serve until a successor could be elected. Should the proposed changes in the By-Laws considered at the December meeting be adopted, most of the work of the present secretary-treasurer would fall on the shoulders of the executive or administrator employed by the Council. The constitutional secretary-treasurer would deal largely with meetings of the House of Delegates.

During my tenure of office there are a number of things that I would like to comment on. One outstanding thing is the lack of communication between the society and its membership. This is not unique with the Illinois Society but is our problem and is a serious one. As an example, on one day five members requested that they be placed on the mailing list for the Springfield Newsletter. When the requests were received, a check of the records showed that three of them had been receiving the letter for weeks. This is not an isolated incident but occurs many times during the year. How to correct this condition is a problem to which we all should give a lot of thought.

The consolidation of the Chicago and Monmouth offices should result in a much better servicing of our committees. At present the Chicago office is the clearing house of the majority of the committees while the Monmouth office handles most mass mailings. Both offices had added burdens this year because of increased activities on the legislative front, especially with reference to the Forand Bill (H.R. 4700), the setting up and maintenance of a panel for the newly established impartial medical testimony program and the development of prepaid insurance for people over 65 years of age. During the first two months of 1960 the Monmouth office handled over 125,000 pieces of outgoing mail in addition to the ordinary routine. During the same period the office processed dues from approximately 3,000 members to whom membership cards were mailed.

The loyalty and devotion of the employees of the society have been outstanding. Long hours and additional work have been taken without complaint. The society is fortunate in having such people in their employ. They have aided the secretary in many ways in the performance of duties.

During my tenure of office I have received every possible courtesy and assistance from the officers and from those members with whom I have been in contact. I always wonder about the relatively few physicians who devote their time and energy to organization work. Very often the people who make the sacrifices receive little

thanks from their colleagues. The rank and file of our profession do not seem to be aware of the threats that are being made to the private practice of medicine. If they realized the danger they would be jarred out of their complacency.

Physicians Placement Service

As mentioned in annual reports of the Physicians Placement Service in former years, this service is a direct consequence of the Procurement and Assignment Service, which ended with World War II hostilities.

Since the April, 1959 report the following 23 communities have secured physicians through our Physicians Placement Service: Camp Point, Chadwick, Virginia, Germantown, Toledo, Paris, Royalton, Canton, Nauvoo, Carthage, Grayslake, Kinmundy, Lacon, Downs, Carlock, Mansfield, Chester, East St. Louis, Green Valley, Frankfort, Chicago (3 openings for an associate).

In addition to the communities listed above, 19 other communities have been removed from our list after we were advised that they had secured resident physicians. We cannot take definite credit for these cases since the physicians filling the openings were not listed with us. However, the Physicians Placement Service of the AMA has reminded us that in many similar cases physicians filling such openings give credit to the placement services of their societies since they were advised of the openings by friends who had received placement service material. We also removed 10 lists from our active files due to lack of interest on the part of the communities.

The following outline of assistance given to a community and a physician, which culminated in the physician locating in that community may be of interest as it is typical of the service the Physicians Placement Services tries to render to both physicians and communities.

Service to Physician Registrant

11/27/59 Dr. Smith requests information concerning communities in Illinois needing physicians.

11/30/59 Questionnaire requesting detailed information concerning background training and experience sent to Dr. Smith and form inquiry sent to AMA.

12/23/59 Complete list of communities in Illinois needing physicians and data concerning each, together with several maps and pamphlets designed for physicians looking for locations, sent to Dr. Smith following receipt of his completed questionnaire and report from AMA.

1/29/60 Additional information sent to Dr. Smith, including data concerning communities reported as needing physicians since booklet was mailed on December 23.

2/29/60 Dr. Smith removed from mailing list after information received from Community Council that he will locate there.

Service to Community

11/18/59 Community Council reports opening for a physician following death of local physician. Lions Club had reported opening several months earlier but failed to reply to request for further information; need had been verified by county medical society at time original report received.

11/19/59 Questionnaire requesting detailed information re community and pamphlets sent to council.

11/21/59 Completed questionnaire returned by council.

11/28/59 Opening for physician reported by a farmer living near X.

11/30/59 Above letter acknowledged.

12/8/59 Sent X council copy of data we propose to send to all general practitioners registered with our Physicians Placement Service on December 10 along with data concerning other communities reported during past month.

12/8/59 Director, Medical Program, Sears Roebuck Foundation, forwarded copy of economic survey of X. (Not all communities listed surveyed by Sears Foundation).

1/19/60 Council reports no inquiries as result of our December 10 mailing. Requested list of physicians who received this bulletin so that council might contact them personally. Inquired concerning one physician who contacted council as a result of newspaper publicity.

1/21/60 Sent list of general practitioners added to our mailing list during last few weeks.

1/30/60 Inquiry received from council re two physicians; one contacted council after receipt of our notice; second inquiry resulted from ad in JAMA.

2/1/60 Biographical data concerning physicians sent in reply to above inquiry.

2/2/60 Phone call from council chairman re Dr. Smith, referred by our Placement Service; to come on February 4 for interview.

2/27/60 Council chairman advises Dr. Smith will locate here within three weeks. Community sponsored welcoming party when he and wife came to check opening. (Wife an R.N.; married one month; will assist him in office). Community council introduced doctor to pharmacist, neighboring physicians, helped him find home, helped secure information from neighboring medical societies as to hospital staff privileges, etc.

Doctor Smith had been listed with our Placement Service for less than three months; the X Community Council had contacted us about the same time, although earlier efforts had been made by the local Lions Club. It is unusual that files of either physicians or communities are removed from our mailing lists after so short a listing. Many physicians, as well as communities, have been on our mailing lists for more than a year.

At the present time we are engaged in trying to find general practitioners for 120 communities, as well as specialists, especially internists, for several attractive openings.

We send monthly notices to the general practitioners listed with our Placement Service advising them of openings that have come to our attention since the last notices were sent. The AMA informs us that this routine is not followed by most societies, but we feel that it is worth the added effort. We send the communities a list of physicians registered with our Placement Service when requested to do so, but have found that sending the material concerning the community from this office to physicians brings the best results. Most of the communities listed do not have local facilities for mimeographing letters and seem to appreciate our service.

More than 155 general practitioners and approximately the same number of specialists are on our Placement Service mailing list at the present time. New names are added daily and others deleted as they decide on locations.

We continue to receive excellent cooperation from The Sears Roebuck Foundation and the director of its medical program, Mr. Norman Davis. Several of the communities listed with our Placement Service have been surveyed by the foundation and others have fortunately been discouraged from constructing office buildings to attract physicians when the surveys have revealed that the communities do not meet the economic potential desired.

The AMA continues to serve as a clearing house for the placement services of all state medical societies, as well as the services of several specialty organizations. When the AMA receives information that a physician is considering locating in Illinois a copy of his questionnaire containing biographical information is immediately sent to our office. Likewise when an Illinois community advises the AMA that it needs a physician, the matter is referred to us for investigation. Not all referrals come from the AMA, however. Many physicians contact us as a result of a classified ad in the Illinois Medical Journal; others are referred by friends who have received help from our office and by deans of medical schools.

The AMA has assisted in publicizing our service, as well as those of the other state societies and specialty organizations. Articles appear occasionally in the JAMA, and during the past year good publicity has come from the Wall Street Journal, the AMA News, the National Association of Retail Druggists, Medical Economics, etc.

During the past month we have re-mimeographed material concerning all openings for general practitioners in a new form, and the new type of booklet will be ready for distribution shortly. The Council on Medical Service of the AMA recently sent copies of the new booklet published by the placement service of the Massachusetts society. It is printed rather than mimeographed and is very attractive. However,

in order to revise the booklet monthly, as we have done in the past, there would be considerable expense involved in a monthly printing, and the mimeographed booklet serves our purposes adequately.

A copy of the new booklet and other placement service forms will be available in the secretary's office during the annual meeting for any member of the reference committee that considers this report, or others who may care to see them.

It may be assumed that after the new office is located in Chicago we will have many more calls from physicians, as many on our mailing list reside in the Chicago area. However, the number of representatives from rural communities who have called at the Monmouth office during and since World War II will probably decline.

We would like to express our thanks to Miss Dorris Webb of the American Medical Association for her fine assistance in the various activities of the Placement Service.

Respectfully submitted,

George F. Lull, M.D.

REPORT OF THE CHAIRMAN OF THE COUNCIL

As you all know during this fiscal year, Dr. Harold Camp, our esteemed secretary passed away. We were very fortunate indeed to obtain the services of Dr. George F. Lull, who was appointed as secretary to fill the interim until a permanent secretary could be found. Dr. Lull has been doing a fine job, and I am sure that the business of the society has gone along perfectly smoothly under his direction.

Again, as last year, I will reiterate that a lot of the major work has been done by the Council committees of the Illinois State Medical Society, and their programs and accomplishments will not be enumerated in this report. They will be found under the separate committee reports.

As you will recall, at the annual meeting in May of last year the announcement was made that the Edlund report, the management survey report, would be available to all delegates and officers of county medical societies shortly after the next Council meeting in July, 1959. This was accomplished: Shortly after the Council meeting in July, 1959, copies of the Edlund report with the Ad Hoc committee's recommendations were mailed to all delegates of county medical societies in Illinois.

At the October 11 meeting of the Council, it was decided to hold a call session of the House of Delegates on December 12 at the La Salle Hotel in Chicago. This was done.

A complete report on the Edlund survey, as well as the report of the Ad Hoc committee to study this report was made to the House of Delegates. The minutes of the called session of the House of Delegates have been published in the Journal and has been available for everyone to read; therefore it will not be necessary to take up individual items. We will mention, however, some of the major things which were decided upon at this called session.

First, the reference committee appointed to hear the report of the committee on location of the office suggested to the House that the headquarters office be located in Chicago. This was voted on and concurred in by the House of Delegates.

Also at this time, medical care for the aged, particularly those people over 65, was discussed. It was decided that this matter should be referred to the Council for implementation and that every member of the Illinois State Medical Society be given an opportunity to participate in such a program.

You will remember, as reported to the House of Delegates in December, that about 86 per cent of those doctors answering the questionnaire with reference to the care of the aged stated they would be willing to participate in such a program which would constitute payment in full for services as rendered to those people with certain limits on their incomes and wealth.

The Council appointed a committee to study the various Blue Shield plans in Illinois, and after careful consideration, presented to the Council the various plans that were available. The Council then voted to have the Blue Shield plan of the Illinois Medical Service in Chicago underwrite this program for health insurance for people over 65. The committee, having fulfilled its duty, was dismissed.

Mailings were made to every doctor in the state explaining the program of health insurance for people aged 65 and over so that each doctor has had an opportunity to determine whether or not he wishes to participate in this program on a

payment-in-full basis for those people with limited incomes and limited wealth.

Going back to the Rogers, Slade & Hill or Edlund report, the House of Delegates at its meeting on December 12 passed the following recommendation "that the Council make a detailed report covering every item in the Rogers, Slade & Hill report, reserved for Council action." Following is a report on these items.

Recommendation 3, on page 6 "Authorize an Ad Hoc committee to prepare job specifications for the position of administrator. This Ad Hoc committee was appointed with Dr. Percy Hopkins as chairman, and Dr. Hopkins' committee proceeded to carry out this recommendation. Job specifications were drawn up, and about 85 men were interviewed. The field was finally narrowed down to three men and then one man was chosen and appeared before the executive committee of the Council who hired him. His name is Mr. Robert Richards; he will be available about the middle of June. Mr. Richards will be present at our State meeting in May, so that the members of the House of Delegates may meet him.

Recommendation 4, on page 7, "the Ad Hoc committee employ an administrator." This has just been described above and completed.

Suggestion 6, page 19, "interim meetings of the House in centers, other than Chicago." The Council felt that at the present time there was no necessity for interim meetings of the House of Delegates except on unusual occasions, such as the meeting on December 12. Anyone desiring further discussion on this item might go before the reference committee.

Suggestion 8, page 23, "give equal time at council meetings to matters other than legislative." The chairman of the Council can assure the House of Delegates that this has been done this year.

Suggestion 9, page 23, "spread committee appointment more widely and cut down committee assignments given to councilors, not more than one committee for any one councilor." This has been done in so far as possible. As you remember, the Chairman of the Council notified each county medical society secretary in the State of Illinois following the May meeting to send names of individuals who would be willing to work on state committees. By the July meeting of the Council in 1959 only six county medical societies had been heard from. Therefore, the officers of the state society in conjunction with the Council spread the committee appointments as widely as possible and attempted to give more appointments outside of the Council. It is hoped that next year the county medical societies will be more cooperative with the Council, in order that a wider spread of committee appointments may be made.

Suggestion 10, page 24, "Provide Councilors with more advanced agenda and supporting data." I will say that Dr. Lull and his staff have carried this out very nicely, and the Council, I am sure, has received in advance all items which were to be brought before them.

Suggestion 11, page 24, "signing of vouchers by finance committee at other times than during Council meetings." This has been accomplished. The chairman of the Finance Committee holds his committee meetings at times other than the regular Council meeting.

Suggestion 12, page 24, "Consider whether more frequent Council meetings are needed or meetings of longer duration, such as all day or an evening and morning." In view of the fact that the members of the Council spend a tremendous amount of time and effort in attending Council meetings, it was felt that these meetings should be as infrequent as is consistent with the good conduct of the business of the state society. Should more frequent meetings or meetings of longer duration be needed, I am sure the Council will comply with the suggestion.

Recommendation 6, page 29, "Look forward to continuous development of Public and Professional relations including projects in the service of the Public at State and local levels and including the development of many and various programs such as those outlined in the pamphlet, *The Public Relations of the County Medical Societies,* first published by ISMS in 1953." The Ad Hoc Committee on personnel have just about completed their search for a good public relations man as this report is being written. This should be completed within the next few weeks or particularly by the time the state meeting is held.

Suggestion 14, page 31, "Consider whether physician contacts with officials and legislators can be further organized and developed." As you will remember, the Committee on Medical Service and Public Relations made quite an effort to get names of those physicians who were either family physicians or close friends of officials and

legislators. It was felt that these men could make personal contacts more readily than a stranger. This portion of the report has been consummated.

Suggestion 15, page 31, "consider what future relationship should be developed with the Associate Council in Springfield, since he must determine whether to engage more extensively in private practice as a lawyer or to reserve and develop time for the service to the Society." This has already been consummated and the associate council in Springfield is now on full time employment with the Illinois State Medical Society.

Recommendation 7, page 34, "look forward to employing a high-grade well paid editor on full or substantial time." At the present time Dr. T. R. Van Dellen is editor. He is working part time for the state society. He has employed, however, an assistant editor on a full time basis. The employment of an editor either full or part time permanently will be taken up when the administrator takes over the functions of his office.

Recommendation 8, page 34, "authorize an Ad Hoc committee to prepare a job specification for the position of editor." This has been done.

Recommendation 9, page 35, "when the time comes authorize the Ad Hoc committee to make the search for the editor. To use such assistance as it deems best and to arrange with the candidate his contract of employment." This is in the process of being developed.

Suggestion 19, page 38, "continue the effort begun this year to avoid conflict in the time between the House of Delegates and reference committees and the scientific and general sessions." This has been done this year. A new committee for study of the annual meetings has been functioning, and we hope that this committee will be able to rearrange our annual meetings over a period of years and to keep up the continuity of the meetings, so that it will be one of the outstanding state society meetings in the country.

Suggestion 20, page 38, "(Have) an exhibit director for the commercial exhibitors during the Annual Meeting." This is being accomplished. There will be an exhibit director to whom all commercial exhibitors may turn with their problems.

Suggestion 21, page 38, "to determine whether prizes should be offered to registrants at the meetings in order to assure better attendance at the booths of the commercial exhibitors." This is being carried out on the same basis as it was last year. Prizes will be offered.

Suggestion 22, page 38, "that the audited statements by the society auditing firm should show the classification and the amounts of expenditures and receipts connected with the annual meeting, the exhibits and each feature or part of the meeting." This is being done.

Suggestion 24, page 40, "take steps at an early date to purchase for the Chicago Office modern addressing and folding equipment, graphotype electric stapler and duplicator that can handle cards automatically." This suggestion will be consummated when the new Headquarter's Office in Chicago has been established and the executive administrator has had time to consider needs for the new office.

Suggestion 26, page 42, "adopt the actual budget and plan when you know what dues income can be counted on." This is being done.

Suggestion 27, page 43, "quarterly audits instead of annually only." The Council still feels that an annual audit is sufficient and, therefore, has not had quarterly audits made.

Suggestion 28, page 43, "Fifty dollar per diem for the president." The Council passed a recommendation that the officers of the state society be allowed $25.00 per diem during absence from their offices on State Society business. This was passed.

Suggestion 29, page 43, with reference to the audit, "show all travel expense in one place classified under the different accounts. The same for salary, wages, rent and other basic expenses." This has been accomplished.

Suggestion 31, page 43, "a continuing Committee on Committees to keep on developing suggestions for streamlining and coordinating Committees and also, by suggestions of names, to assist in bringing new men into Committee work and in avoiding too many Committee assignments to the same person." This committee has been appointed.

This constitutes all the recommendations of the Edlund report to the Council and the actions taken thereon.

Another forward step taken this year was the institution of a good retirement plan for employees of the state medical society. This plan is now working, and it now furnishes our employees fringe benefits comparable with employees of other large organizations.

The committee working on this did an excellent job and they now have been dismissed.

Another great step forward has been made this year by the Committee on Industrial Health headed by Dr. Richard Bennett. As you know, impartial medical testimony has now been adopted by some of the courts in Illinois. Complete details of this will be given in Dr. Bennett's and Dr. Levinson's reports.

Effective August 1, 1959, the society was successful in securing an increase in fees in the treatment of recipients of the Illinois Public Aid Commission. On that date there was an over-all increase of approximately 50 per cent. Now the fee for an office call is $3.00, a house call $4.50 except between the hours of 10 p.m. and 6 a.m. when the fee for a house call is $6.00.

As stated previously in this report a committee for programming the annual meeting has been appointed. There are nine members in staggered appointments for three years, two years, and one year. Ex-officio members are the president, president-elect, chairman of the Council and the secretary. Also, the chairman of the committee on arrangements. The function of this committee is to develop and coordinate the general assemblies, the section meetings, and the scientific exhibits at the annual meeting.

At the January 31 meeting of the Council, the Committee for the Selection of the Headquarters Office recommended, and the Council approved the new location at 360 North Michigan Avenue, the London Guaranty Building. The space is adequate, its location is near the loop, transportation is good, there is adequate parking nearby, air conditioning is already available, and meals at meetings could be served in the office by the London House. The officers of the society were authorized to negotiate a five-year lease on this location. At the present time it is expected that the Monmouth Office will be moved to Chicago about June 1, immediately following the annual meeting. The new executive secretary is expected to assume his full time duties on or about June 15. The problems of new personnel and also establishment of a Springfield Office will be taken up subsequent to completion of the office set-up in Chicago. Members of the Council in the past two years during my period of chairmanship have done a tremendous amount of work. There has not been one single individual who has shirked his duty. The cooperation has been excellent during this period of reorganization, and I am sure that all actions taken were thought to be to the best interest of the medical profession of Illinois as a whole.

I wish to express my deep appreciation to all members of the Council, the officers, and to the individual members of the Illinois State Medical Society for their support and cooperation during this period of my service to the Council and the Illinois State Medical Society. I trust that when the reorganization is complete we will have a closer-knit and better functioning society that will be better able to serve each member.

Respectfully submitted,

Burtis E. Montgomery, M.D.
Chairman

REPORT OF THE DISTRICT COUNCILORS

First District

The First Councilor District of the Illinois State Medical Society is composed of a strong group of societies. With few exceptions, their meetings will average six or more per year and are well balanced between educational and policy meetings. The delegates to the state society have been stable for several years, and they are men who know and are interested in the societies' problems.

A meeting of the delegates was held in Rockford by the councilor, before the December, 1959, Special House of Delegates Meeting. At that time, all pending problems to be presented at the special meeting were reviewed and discussed. A course of action was devised and presented at the House of Delegates meeting. Another such meeting will be held before the annual meeting.

Before the annual meeting, I will have visited as many societies as possible. Several 50-year membership certificates have been presented. Efforts to promote sound legislative and public relations programs were well received, and the response was excellent. No problem of local origin that could not be settled within the organizations came to my attention.

Respectfully submitted,

Carl E. Clark, M.D.

Second District

The component county societies of the Second District have held regular meetings during the past year. Scientific programs have been supplied

by doctors from Chicago, Peoria, and Rockford. A great interest has been shown in legislation which would affect medical service to the elderly of the population. Meetings have been held at which special speakers have talked in reference to the Forand Bill. The county societies, for the most part, are well organized; and the individual members are active in their organizations.

There was one public relations problem which fortunately resolved itself very satisfactorily.

Your councilor is chairman of the Advisory Committee to the Women's Auxiliary to the Illinois State Medical Society, is a member of the Committee on Constitution and By-Laws, and is an alternate member of the Committee on Maternal Welfare.

Plans are being made for a postgraduate meeting for the Second District during the latter part of April. This should be of benefit to all of the members of the profession.

At the special meeting of the House of Delegates in December, 1959, there was a caucus of delegates of the Second District, and committee members were appointed to aid county societies not having the following committees: Ethical Relations Committee, Grievance Committee, and Prepayment Committee.

Your councilor attended the Conference on the Care of the Aging, held in Springfield in September, 1959.

Your councilor has attended all of the Council meetings held during the year, and he has attended meetings of all the county medical societies in the district and has given short talks at these county meetings.

Your councilor was honored by an invitation to attend a meeting of the Tazewell County Medical Society, at which he spoke on the Forand Bill. Present at the meeting were Senator Everett M. Dirkson and Representative R. Michael. The Tazewell County Medical Society is to be commended for its marked enthusiasm in opposing the Forand Bill.

I am completing my first year as your councilor for the Second District. It takes time to become acquainted with the problems of the Illinois State Medical Society as they are presented to the Council. It also takes time to meet and to know all of the doctors in the county societies in the district. I hope that you will bear with me in patience and understanding so that I may better know, and better serve you. I wish to thank the officers, councilors and the secretary of the Illinois State Medical Society and the folks in the offices in Monmouth and Chicago for their invaluable help. I am very thankful to the presidents, secretaries and members of the medical societies of the Second District for their cooperation, courtesies, and hospitality during the past year.

Respectfully submitted,
Ralph N. Redmond, M.D.

Third Councillor District

The Chicago Medical Society, ever mindful of its responsibilities to the public and its obligations to the profession, continues to develop new activities and to extend its regular program. Every effort is made to bring the latest advances in medical science to the physicians of Cook County and to promote good health for the people in this area.

Committee on Professional Orientation

The Committee on Professional Orientation has had a successful year with all members participating. Our series of bi-monthly meetings has an attendance of new members each time ranging from 40 to 60. We have carefully surveyed the type and method of indoctrination presented by other medical societies throughout the country and have endeavored to enll out that which most nearly meets the needs of the Middle West. In attempting to educate new members in the values inherent in society membership, we have found value in writing as guests of the program the doctors comprising the Membership Committee as well as the society officers. We appreciate their cooperation.

Doctors' Emergency Service

The Doctor's Emergency Service of the Chicago Medical Society has given emergency care to over 55,000 cases since its inception. These were home care cases. Over one-half million dollars were collected by the doctors for this service. Had these cases been hospitalized for a minimum of three days, 165,000 hospital day beds would have been used, at a cost of over $4 million.

Grievance Committee

The Grievance Committee of the Chicago Medical Society handled 304 complaints during the year 1959 — total number of doctors written to were 353. Most of the complaints were due to

misunderstanding or relating to doctor's fees and were settled without the necessity of calling in the doctor and complainant. In some cases the committee recommended an adjustment in fees and a friendly settlement was reached. Ten doctors were called in and eleven complainants and the cases were settled satisfactorily. A few cases required additional investigation. Nine doctors were reprimanded for not being cooperative with the committee and 31 complaints received were from obviously psychotic people. Four cases were referred to the Committee to Investigate and Consider Informal Charges of Unethical Conduct. Two cases referred directly to the Ethical Relations Committee as the doctors did not cooperate with Grievance Committee or the Committee to Investigate and Consider Informal Charges of Unethical Conduct.

The committee has been increased to nine members and they should be commended for the fine work they do in trying to settle these complaints. A small portion of the number of complaints received represents justifiable grievances against physicians.

Committee to Investigate and Consider Informal Charges of Unethical Conduct

This committee acts as a fact finding body for the Council of the Chicago Medical Society. Physicians charged with violation of ethics are heard informally before this group. If charges are found unwarranted, recommendations that no further action be taken are brought to the council. If charges of misconduct are substantiated upon evaluation of the evidence, recommendations are made to the council that the physician be charged formally with unethical conduct and that he be summoned before the Ethical Relations Committee.

In most instances, problems have been adequately mediated at the committee level. Fourteen complaints were handled during the year.

Ethical Relations Commmittee

The Ethical Relations Committee is pleased to report that very few cases have been referred to it during the past year. Much of the work has been answering inquries on ethical practice.

The Insurance Programs

The Committee on Insurance supervises and adjudicates matters on the insurance programs of the society. The first insurance program was a true group on health and accident which has over sixty percent participation. This program completed six years of operation on November 30, 1959. The carrier reports that the insurance experience is excellent and is about to offer additional benefits.

The second insurance program was term life insurance. It was designed originally for the younger members but was extended to include individuals 64 years of age. There have been 42 death claims and the beneficiaries have received $424,500.

Both plans are open to new members without presenting evidence of insurability and both plans are operating soundly.

Public Relations Committee

The organization of the medical society of this district is designed to handle a large volume of business and many public relations. Responsibilities of public relations are divided among many committees. However, designated public relations has had under consideration during the last year the larger amount of material in various publications which is unfair and detrimental to the medical profession. In some neighborhood areas, individuals joined the local Chambers of Commerce, which can possibly benefit the medical profession.

Clinical Conference Committee

The Chicago Medical Society presented its sixteenth Annual Clinical Conference, March 1 to 4, 1960, at the Palmer House.

A faculty of 33 outstanding teachers presented scientific papers covering all phases of medicine in the Grand Ballroom. In addition, there were color motion films and live color telecasts from Cook County Hospital daily in the Red Lacquer Room. Four instruction courses each day provided the registrants with an interesting educational experience. The scientific exhibits were well received and three awards were presented.

In spite of snow and cold weather more than three thousand physicians registered for the meeting and the total registration was 5,374.

Postgraduate Courses

The two postgraduate courses, one in obstetrics and gynecology, and the other in pediatrics, were held at the Morrison Hotel, Chicago, during the later part of October and the first week in November, 1959. Both courses were well attended

by physicians from all over the country and also Canada. A goodly number of Chicago physicians were also in attendance.

These postgraduate courses which are held each fall under the supervision of the Chicago Medical Society are always very popular to the practicing physician. The lectures were presented by outstanding and well recognized physicians. This year seminars and conferences were held in addition to the lectures, as well as discussion sessions.

Polio Immunization Committee

The Chicago Medical Society is eager to stimulate an immunization program during the early spring of 1960. There were about 65 cases of poliomyelitis in the county in 1959, a few of whom had had some previous immunization. Before the days of vaccine, epidemics occurred every three years: 1937, 1940, 1943, 1946, 1949, 1952. Even after the initiation of the poliomyelitis immunization program in early 1954 and 1955, the Cook County area had a major epidemic in 1956. Epidemiologists fear that 1960 will be a crucial epidemic year unless a very large percentage of the susceptible population is immunized effectively before mid-summer.

For greater safety, it is recommended that not only the usual dosage be given but that the fourth booster dose, or even the fifth booster dose, be given to immunize our young population.

Committee on Polio Control

The Committee on Polio Control has continued its activities of publicizing the need for immunization. These activities were reported in the handbook for 1959. It was gratifying to see a significant increase in the number of persons immunized due very probably to the efforts of our society and of other organizations.

Requests for information in considerable numbers continue to reach the committee and are promptly answered. Members of the committee continue to serve as the Advisory Committee on Polio to the Department of Public Health and on other voluntary agency committees. The committee expects to step up its program of disseminating information regarding polio immunization with the approach of the polio season.

Tuberculosis Control Committee

In the City of Chicago during 1958 there were 3,059 new tuberculosis cases reported with 374 deaths. In the suburbs of Cook County there were 346 new cases and 60 deaths.

Preliminary 1959 figures for Chicago residents reveal approximately 2,785 new cases with 330 deaths occurring within the city limits. This is a continued decrease in morbidity and mortality of this disease.

Preliminary figures for suburban Cook County remain about the same as 1958, probably because there has been a marked increase in population in the suburbs during the past ten years.

Tuberculosis case-finding stood at an all-time high during 1959 with 1,039,411 x-ray survey films done on a cooperative basis with the Municipal Tuberculosis Sanitarium, the Suburban Cook County Tuberculosis Sanitarium District, and the Tuberculosis Institute of Chicago and Cook County (The Christmas Seal organization), and all of the full-time health department and health agencies in a cooperative effort to eradicate the disease as early as possible. Outstanding among these programs in tuberculosis detection was the x-raying at in- and out-patient services of Cook County Hospital. This program has been most productive during the year 1959.

Despite the fact that the mortality from tuberculosis has decreased during the past ten years, tuberculosis still remains the number one public health problem in Cook County.

Woman's Auxiliary Activities

1960 is drawing to a close and we are proud of the accomplishments we have made.

Community Service Day was well attended at which time Norma Lee Browning was the principal speaker. We were also honored to have our national president, Mrs. Frank Gastineau; state president, Mrs. John Van Prohaska, and state president-elect, Mrs. Charles Wunsch, and our own Dr. George C. Turner as guests.

We were proud to staff the hospitality and legislative rooms during the Clinical Conference for the Chicago Medical Society.

Many contributions were received in memory of our doctors and friends who had passed on. This assisted the projects such as American Medical Educational Fund and Benevolence. Recruitment was supported by our Ways and Means Party. Subscriptions to the Bulletin have been well supported.

Through the efforts of our members we are proud of the cooperation we have given Dr.

Breed and the Chicago Medical Society on the Forand Bill. Our district meeting was devoted to the subject of medical legislation. Mr. Walter Oblinger, associate counsel for Illinois State Medical Society, was our guest speaker. He presented a detailed explanation of the Forand Bill and other medical legislation.

It has been due to harmony and good will of each individual assuming his responsibility that has made this year successful. Our desire is that those who succeed us be blessed with an outstanding 1960-61.

Respectfully submitted,
E. A. Piszczek, M.D.
Caesar Portes, M.D.
Earl H. Blair, M.D.
Harry J. Dooley, M.D.
John L. Reichert, M.D.
H. Close Hesseltine, M.D.

Fourth District

The constituent societies of the Fourth Councilor District have had few problems the past year.

There have been no postgraduate conferences held in this district during the past year, and it is hoped that for the coming year one or several of the larger counties arrange for such a conference.

The Special Session of the House of Delegates held in December was well attended by the delegates from the constituent counties. In preparation of the delegates for the consideration of the changes recommended for the Illinois State Medical Society by Rogers, Slade & Hill, a meeting of the delegates of this councilor district was held in Peoria on October 4, 1959. Another such meeting is slated to be held in Galesburg on March 31, 1960, in preparation for the problems to confront the House in the annual meeting.

As provided in the changes in the constitution at the 1959 annual meeting of the House, members were elected to serve on the Ethical Relations Committee, Grievance Committee and the Committee on Prepayment Plans and Organizations. The Ethical Relations Committee was convened in one county, and the problem was finally resolved.

It is suggested to county officers and to the members of the program committees of the counties that they make provision with the councilor of the district for a meeting during the year. Counties have been visited by your councilor and it is planned that those not visited at the time of this writing, will be before the annual meting. During this year Fifty Year Pins were presented to Dr. Clifford Ellis of Rock Island County and to the late Dr. Harold M. Camp of Monmouth.

All of the council meetings to the date of writing have been attended by your councilor.

I wish to thank the district for the most excellent support in every way from the officers and members of the local society.

Respectfully submitted,
Fred C. Endres, M.D.

Fifth District

During the past year the component societies of the Fifth District have continued active and have cooperated fully in the projects sponsored by the state society. Regular meetings have been held, and attendance seems to have increased in some of the societies. No serious problems have arisen, and no matters have occurred to necessitate metings of the district Ethical Relations, Grievance, or Prepayment Plans and Organizations committees. County Legislative committees have shown increased activity and have functioned with increased efficiency. One conference with district delegates was held on October 8, 1959. Actions of the preceding Council meeting were discussed, and members of the Ethical Relations, Grievance, and Prepayment Plans and Organizations committees elected.

Bloomington was the site of one outstanding meeting for McLean County members on January 20, 1960. County society members, the Auxiliary and office personnel, and both members and non-members of the Medical Assistants Association heard Rep. Leslies Ahrends discuss the current legislative agenda in Washington. Also present at this meeting were the area's state senator and representative. Commendations are in order for Dr. Raymond E. Baxter, county legislative chairman, and his committee for arranging this meeting.

The Auxiliary has continued to be active in most of the counties. Various local projects have been continued, and meetings have been held for information and action on legislative matters.

The Fifth District annual meeting is to be held in Bloomington this year, and the preliminary program indicates an interesting agenda.

Springfield has been the location of several committee and larger meetings having state-wide interest during the past year. Most outstanding was the day-long Conference on Aging on Sunday, September 27, 1959. A Council meeting was held in conjunction with this conference. Representatives from county societies totaled 129. This meeting replaced the usual annual Secretaries' Conference in Springfield. The number of meetings, both large and small, held in Springfield will be considerably increased next year — "legislative year."

The state society and medicine's progress was again brought to the attention of the public at the Illinois State Fair, August 14-23, 1959. The exhibit booth, in a choice location in the grandstand, displayed three AMA exhibits of current interest, "Mechanical Quackery," "Nutritional Nonsense" and "Immunization for Family and Community Protection." Motion pictures on related subjects were shown each day from morning through evening, and literature of similar nature was distributed. This project seems to be developing increased interest each year.

Three Fifty Year Club certificates were presented during the year to members of the Sangamon County Medical Society, Drs. Frederick P. Cowdin, Charles F. Harmon, and Harry H. Southwick.

The Sangamon County Medical Society in conjunction with the other component societies of the Fifth District inaugurated a campaign during the fall to retain the administrative office of the society centrally located and downstate, to better serve and represent the downstate members as well as to more thoroughly implement the legislative program. This project failed through the recommendations of the Reference Committee at the special meeting of the House of Delegates.

One postgraduate conference was held in the district during the year — in Springfield, March 3, 1960. Attendance at the afternoon clinical session was 75 and at the dinner, 59. This was considered good in view of sub-zero weather and one foot of snow.

During the past year I have attended all meetings of the Council and have served on the following committees: chairman, Illinois Medical Journal Committee and a member of the Editorial Board; chairman, Narcotics Committee; member of the Executive Committee, Harold M. Camp Memorial Committee, Insurance Committee, Birth Certificate Committee, American Legion Advisory Committee; advisory member of the Secretaries' Conference Committee, and member of the governor's Necropsy Board. I also attended the AMA annual meeting in Atlantic City and the clinical session in Dallas, Texas.

To the officers, delegates, and members of each county society of the Fifth District I am sincerely grateful for the assistance and helpful suggestions they have given me during the past year.

Respectfully submitted,

Jacob E. Reisch, M.D.

Sixth District

The component Medical Societies of the Sixth District function smoothly. Regular meetings are held and membership is high. For this the officers should be commended. Many members take an active part in the business of the state society, serving as delegates to the AMA and heading active committees. This past year there have been no members eligible for membership in the Fifty Year Club. One of the societies in the District has instituted a new plan whereby the dues include meals at each of the medical meetings: This has resulted in greatly increased attendance. District committees on Ethical Relations, Grievances, and Prepayment Plans have been established. Your councilor has enjoyed his visits to the county societies and wishes to express his sincere appreciation for the many courtesies and the hospitality extended on these occasions. The Woman's Auxiliaries in the district are functioning effectively, which is most gratifying.

Your councilor has attended all the meetings of the Council and serves as chairman of the Liaison Committee to the Illinois Bar Association and chairman of the Birth Certificate Committee. He is a member of the Committee on Impartial Medical Testimony, a member of the Advisory Committee to the Medical Assistants Association, a member of the Committee on Nursing, and a member of the Committee on Poliomyelitis Control. Your councilor was honored to attend appreciation dinners for Dr. O'Neill and Dr. Camp, as well as the meeting of the AMA in Atlantic city. The secretaries' Conference was again held in Springfield and your councilor was privileged to serve in a minor role. This conference will be headed in 1960 by Dr. Moore of the Madison County Medical Society.

To the officers and members of the county societies I am most grateful. Their continued cooperation and helpful advice has made it a pleasure as well as an honor to serve as councilor. Appreciation is also extended to the officers and councilors of the Illinois State Medical Society, the Secretary of the society, and those who function in the Monmouth and Chicago offices.

Respectfully submitted,

Newton DuPuy, M.D.

Seventh District

All the component societies have been alerted and responsive to the Forand Bill threat. The societies as a whole have targeted the House Ways and Means Committee as well as the Illinois Representatives and Senators, voicing their individual and collective protests.

The aging problem, its fee schedule, the questionnaire, and the Blue Shield offering have been closely followed. The "Over-65" program of the Illinois State Medical Society which has been approved offers a workable solution in this ever rising situation.

There were three District Committees created at Vandalia, Illinois, on November 22, 1959, to conform to Section III of Chapter VIII of the Illinois State Medical Society's Constitution and By-Laws.

1. The Ethical Relations Committee
2. The Grievance Committee
3. The Committee on Prepayment Plans and Organizations

To date these committees have had no occasion for call meetings. Members serving on these committees are well informed and capable to help counties that do not have similar committees.

One postgraduate meeting was held at Centralia on April 16, 1959, at the new St. Mary's Hospital with its magnificent facilities. The evening program, given by the Illinois Academy of General Practice, was a well attended and successful session.

Two Fifty Year Awards were presented during the year. On May 12, the Christian County Medical Society members and their wives honored Dr. Louis H. Miller at a dinner at the Hotel Frisina in Taylorville. On June 25 the Clay County Medical Society members and their wives honored Dr. Thomas L. McCullough of Flora. Both were presented an Illinois State Medical Society's Fifty Year Club Membership and pin.

The Seventh District enjoys a very active Woman's Auxilliary, and it was your councilor's great privilege to attend their annual meeting and address them at the Country Club of Decatur on October 27.

Your councilor wishes to express appreciation and deep gratitude of the cooperation and efforts given by the County Medical Societies in the Seventh Councilor District.

Respectfully submitted,

Arthur Goodyear, M.D.

Eighth District

Medical affairs in the Eighth District during the past year have gone along at a smooth pace. No serious problems of a professional or ethical nature have arisen. To my knowledge, none of the county societies have had any problems which could not be solved within respective societies.

Despite a variety of trials at postgraduate professional education, there is still no 100 per cent satisfactory solution to the problem. Three postgraduate conferences have been suggested for the district. One has been accepted. We will just have to wait and see what the response to this type of postgraduate education is. Whether other ways than those that have been tried would be more successful only time will tell, and we will have to await the request, activity, and decisions of the specific counties in order to ascertain whether a change can be made.

The district is now, generally speaking, well covered with hospital facilities. True, there are probably times when admissions are difficult; but, by the same token, it is estimated that probably 20 per cent of all hospital beds are not occupied for care of acute illness. The construction of a new facility in Crawford County will leave very few areas (which truly could support a hospital) in the Eighth District not provided reasonably well with available hospital beds. Because this is a rural district some people have to go some distance to get a hospital bed, but the number of beds appears to be adequate.

It seems to this councilor that our pressing problem for the next ten years will be to find beds of the custodial type for those with chronic diseases of a degenerative character. Conversion of tuberculosis hospitals into chronic disease institutions and the extension of good, fire-proof,

county-operated infirmaries appears to be the avenue we will have to take.

So far as the Council's activities for the society is concerned, this has been an extremely busy year. The loss of Dr. Harold Camp, our secretary for so many years, leaves a tremendous void in the organization. The reorganization plans submitted by a survey team certainly call for a change in much of our past thinking. As expressed at the House of Delegates meeting last year, more and more members of the profession will have to contribute of their time, efforts, and money in order to preserve the high level of personalized practice we have had in our republic.

This councilor served on the Legislative Commission which re-wrote the Medical Practice Act. Since perfection hasn't been attained in many, many generations, perfection was not obtained in rewriting the practice act. However, I would like to point out that the amendments passed by the Legislature were all unanimously adopted by the commission and I sincerely believe they are in the best interest of the people in Illinois as well as of those who, now and in the future, practice medicine.

Respectfully submitted,
Harlan English, M.D.

Ninth District

Another year has come and gone fairly rapidly. This has been a year of many significant changes in the administrative setup of the Illinois State Medical Society.

The members of the county medical societies of the Ninth District have been very cooperative in all the procedures and programs which have been initiated, and I am very grateful to them for their support.

As initiated last year, we have had about four meetings of the delegates and officers of the local county societies following the Council meetings to discuss those things brought up and acted upon by the Council. There has been fair attendance at most of these meetings; however, the councilor probably called a meeting at a very bad time on Sunday, February 14, at 2:30 p.m. at which no one except your councilor was present. This being Valentine's Day, it was excusable.

You are already familiar with the new constitutional committees of the Ninth Councilor District appointed in October 1959 as follows: On the Grievance committee S. P. Ward, Metropolis,

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for one year; Gilbert Ranson, Fairfield, for two years; and W. I. Lewis, Herrin, for three years, chairman.

The Ninth District committee on Prepayment Plans and Organizations was C. K. Wells, Mt. Vernon, for one year; Andy Krajec, West Salem, for two years; chairman, Robt. W. Ferrell of Eldorado for three years. No matters have been referred to either committee.

It is again my hope for better communications between the county medical societies and the officers and councilors of the state medical society. I still believe the idea of district meetings following each Council meeting, to acquaint each county society with the problems and actions of the Council, certainly should be of value, particularly to the delegates at the annual meeting.

Again, I wish to thank all the members of the local county medical societies, the members of the Council and the officers of the Illinois State Medical Society for their excellent support and friendship during the past year.

Respectfully submitted,

B. E. Montgomery, M.D.

Tenth District

The past year has been characterized by considerable activity of medical societies in the promotion of the extensive orientation of the membership on the disadvantages of the Forand Bill. Mr. Albert Scott made three trips into the district covering and giving his explanation of the disadvantages of the Forand Bill before four county medical societies. The councilor of the district covered four of the other societies, and one of our delegates covered his own county. It is, of course, difficult to estimate the value of this extensive educational work, what it will produce or has produced. However, it can be said that a definite effort was made. I think the majority of the membership was given full orientation on the defects of this legislation.

We also have been confering with the membership in this district relative to the reorganization program of the state medical society as often as possible, disseminating the pertinent points of this program; and all of the delegates have been informed and given an outline of the Edlund survey and the recommendations of the Ad Hoc Committee which, as we all know, were thoroughly discussed at the Special Meeting of the House of Delegates December 12 and 13, 1959.

We did not have a postgraduate conference in the Tenth District during 1959-1960 as it was felt that this type of program was not wanted and was not requested by any society within the district. It has also been noted that the general practitioners of the area have an opportunity to attend the Academy of General Practice Conferences, one being held in Belleville and another in a neighboring county at Herrin. However, this does not cover everyone who should be exposed, but it does tend to eliminate the necessity of the Illinois State Medical Society putting on a postgraduate "conference-type program" within the district.

The activity of the various county medical societies in the district has been above average during the past year. Of course, we missed the viewpoints of Dr. Paul Baur of Cairo, who has left Cairo and the state for residence elsewhere. He had served four years as Mayor of the City of Cairo and is reported to have done a good job of policing the city. However, shortly after the end of his term he left the area. I presume there is no connection between his being Mayor and his leaving. We certainly hope that Alexander County can come up with another energetic M.D. to represent it at the state level.

I wish to take this opporunity to thank all of the officers of the county medical societies and their delegates for their loyalty and support during the past year. It has been a pleasure to work with the county societies in the Tenth District.

Respectively submitted,

Willard W. Fullerton, M.D.

Eleventh District

Your councilor of the Eleventh District has found the first year in office most rewarding. All the component societies were visited in the past year. Short talks on current problems were given at meetings of the Ford, Iroquois, Kankakee, DuPage, Kendall, and Will-Grundy County Medical societies.

The impression was gained that a wholesome interest exists in the activities of the Illinois State Medical Society. Moreover, one gleaned the feeling that maintaining liaison by the State Medical Society at the grass roots level is a prerequisite to good medical relations.

Contact with the medical societies in the district was maintained by telephone, and a meeting of delegates was called to discuss problems.

It is gratifying to report that the medical societies of the district, both large and small, have displayed a good grasp of the issues facing the medical profession. In fact, some of the smaller societies vigorously applied themselves, by meeting with State and National legislators to air their views, while the larger medical societies also gave good account of themselves in this respect.

Most county medical societies in the district hold regular meetings, and the programs are of high caliber.

No serious problems required the attention of the councilor in the past year. It is to be hoped that in the future the component societies will make more use of their councilor in matters concerning policies, whether they be local or state-wide in nature. This is particularly true in regard to presenting resolutions before the House at the annual meeting. It is suggested that the councilor be furnished with a copy beforehand so that helpful suggestions may be offered to implement their effectiveness.

A fifty year award was presented to Dr. Lester T. Hills at a dinner held in his honor by the members of the DuPage County Medical Society and their wives on October 21.

Your councilor has attended all the meetings of the Council in the past year. He has also functioned on the committees of Medical Economics and the Women's Auxiliary.

Grateful appreciation is hereby expressed to all the officers and members of the component medical societies for their cordiality and excellent cooperation in the past year.

Respectfully submitted,

Bernard Klein, M.D.

COUNCILOR-AT-LARGE

A physician reaches the peak in the bestowal of honors by his colleagues in Illinois when he is installed as President of the State Society. The period of ascendancy is brief, and merely a prelude to a descent. This, we all realize and accept.

The position of councilor-at-large, the step after reliquishing the reins of the chief officer of the society, is a welcome interlude in the return to a position of service to medicine which carries with it no official title. It provides an opportunity to observe.

As your councilor-at-large in the last year, it has been my privilege and pleasure to watch my successor as president, his corps of officers, and the Council carry on a program of reorganization which was first proposed during my term. The vigor with which they attacked the problems and the plans they formulated will establish the operation of the sciety on a highly efficient basis, and increase its stature.

And, now that I am about to leave the "offical family," I thank you for the opportunity to have served the medical profession. I hope you will continue to assign duties to me in the future.

Respectfully submitted,

Raleigh C. Oldfield, M.D.

REPORT OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

June 8 to 12, 1959, in Atlantic City
December 1 to 4, 1959, in Dallas

The report of the AMA Commission on Medical Care Plans, relations between medicine and osteopathy, the report of the Committee on Preparation for General Practice, and the issue of compulsory Social Security coverage for self-employed physicians were the major subjects which brought important policy actions by the House of Delegates in Atlantic City. Details of these matters were reported in the Journal of AMA and in the June 29 issue of AMA News.

Dr. Percy E. Hopkins was elected to the Board of Trustees.

At the Dallas meeting, freedom of choice of physicians, relations between physicians and hospitals, a scholarship program for deserving medical students, and relative value studies of medical services were among the major subjects acted upon by the House of Delegates. The December 14 issue of the AMA News carried details of these actions.

W. C. Bornemeier, *Chairman*
Everett P. Coleman
Harlan English
Frank Fowler
Maurice Hoeltgen
B. E. Montgomery
J. M. Pheiffenberger
H. Kenneth Scatliff
Carl Steinhoff
Leo P. Sweeney
C. Paul White

REPORTS OF STANDING COMMITTEES (CONSTITUTIONAL)

Committee on Archives

During the last half century medical discoveries have been so rapid and outstanding that most of us are inclined to think that all progress in medicine is of recent origin. In this day of wonder drugs and milliequivalents it is easy for us to forget that this progress would have been impossible without the preparatory work which was done before this period. The foundations laid down during the nineteenth century by shrewd observers and investigators who worked with what we today would consider very meager and crude equipment, have made our present achievements possible. The history of the work done by these men makes fascinating reading.

It is so difficult just now to keep up with the present that it is natural to ignore and disregard the past. None of us should live in the past, but we should not get so busy with the present that we forget what has happened before our time and fail to use the lessons it can teach us when planning for the future. A good example of this is the lack of interest which many of us display in considering the Forand Bill. A casual glance at medical history in this and in foreign countries will demonstrate the dire effects of such legislation on our profession and on the general welfare of our nation.

Dr. Paul B. Youngberg of this committee suggested last year that hospital staffs throughout the state collect old records, documents, books, and instruments and display these collections in suitable display cases in physicians' libraries in our hospitals. We hope that this has aroused some interest in such projects. The chairman of your Archives Committee has made a large collection of old medical books of the eighteenth and nineteenth centuries which will be presented to his local hospital library.

It is suggested that any material mentioned above should be forwarded to your Archives Committee if it is not to be preserved in local collections. It is also suggested again that events of importance to our society be forwarded to the "News of the State" section of the Journal.

Respectfully submitted,

Tom Kirkwood, M.D.,
Chairman
J. J. Moore, M.D., *Secretary*
Paul P. Youngberg, M.D.

Medical Service and Public Relations

The last fiscal year was a particularly strenuous one for the Committee on Medical Service and Public Relations. In the early part of the year, your committee was faced with legislative problems at the state level. With the adjournment of the Legislature, attention was turned to the national legislative front where medicine was confronted with its greatest crisis in a decade.

At the time of the writing of this report, the Forand Bill (H.R. 4700) was still a threat. However, we are confident that sufficient active interest has been aroused in the medical profession and among the lay people of Illinois to impress our representatives in Congress by a heavy volume of mail urging a vote against its passage.

The 71st General Assembly met in the first half of 1959. An unusually large number of measures affecting the medical profession went into the hopper. This put a heavy burden upon our attorneys, Mr. Walter L. Oblinger, Mr. Albert Scott, and Mr. John W. Neal.

There were many bills on which the society took a stand. We supported many, proposed amendments to others, and opposed some. In doing so, we were guided always by the yardstick of what was the best for the people of Illinois and for the continued protection of the standards of medical care in Illinois. When a tabulation of the bills passed and the measures killed was made at the close of the session, the results were particularly gratifying.

Your society offered or endorsed 21 bills, all of which were passed. Among these were amendments to the Medical Practice Act. The most important ones included S.B. 665, changing the elapsed time of the medical course to permit medical schools to adopt the quarter system; H.B. 1569, requiring citizenship of medical licensees; S.B. 668, stipulating that a medical licensee applicant must take additional training upon failing the examination five times; and S.B. 669, increasing the penalties for the illegal practice of medicine. There were others which materially improved the Act by providing additional safeguards.

We offered H.B. 6 and H.B. 156, which clarify the law with reference to the testamentary disposition of the human body or parts thereof by will or written consent. H.B. 1280 was enacted, providing for physician-patient privileged communication.

Other important bills passed included S.B. 723, permitting Illinois osteopaths meeting certain requirements to take postgraduate training of not less than 248 hours and to become eligible for the regular examination to practice medicine in all its branches, and S.B. 724, enlarging the Medical Examining Committee to seven to include one chiropractor and one osteopath.

Numerous bills involving the sale of narcotics were presented. We successfully supported some and were upheld in our opposition to others.

When the Legislature adjourned, our efforts were concentrated on the national legislative problems, the chief of which was H.R. 4700, popularly known as the Forand Bill.

Our campaign started with the education of the medical profession regarding the importance of arousing the public to the dangers in the bill. It was necessary to carry this campaign into every part of the state. A speakers bureau was established. The nucleus of this was our staff of three attorneys, supported by councilors and other members. Mr. John A. Mirt of the Chicago office arranged meetings at the county level.

Through this setup, speakers were sent into about 90 counties. The others had only a few members and were covered by mail. As a result of this drive, coupled with intensive education through the Springfield Newsletter, which reached a circulation of 1,450, and through correspondence and literature, Illinois physicians became thoroughly indoctrinated in what to do.

Our next step was to reach the public. Individual physicians were asked to obtain the support of patients, friends, and local organizations. The Auxiliary was requested to aid in the campaign. More than 200 state organizations were sent informative material and asked to join medicine on the ground that if the bill passed there would be an additional tax burden as well as deterioration in the quality of medical care. Lay groups were provided speakers.

This campaign bore fruit. Among the speakers at our annual Legislative Conference in February were representatives of the American Farm Bureau Federation, Catholic Hospitals, Illinois State Chamber of Commerce, Health Insurance Association, Illinois Nursing Home Association, and Illinois State Dental Society.

The result has been a flood of mail to the Illinois representatives in Congress urging them to vote against the Forand Bill and like measures.

At the same time, your committee, in accordance with a directive from the House of Delegates, worked zealously to lay the groundwork for a low-cost prepayment plan for those 65 or over. The first step was the sounding out of physicians regarding their willingness to accept a reduced schedule of fees for services to the aged within a certain low income range.

Replies were received from about 4,000 physicians, an unusually good response to a questionnaire. It was most encouraging to learn that about 85 per cent of those answering were ready to cooperate in such a plan. The House of Delegates at its special meeting in December directed the Council to develop a fee structure and submit it to the members for their individual opinion.

Thus, for the greater part of the year your committee was compelled to concentrate its activities against the Forand Bill. As soon as this problem is resolved satisfactorily, we are prepared to take up other matters which have been deferred.

The Council, realizing that the Forand Bill and like bills are the greatest threats to medicine that have arisen in 10 years, has given your committee free hand in carrying out an aggressive campaign. We have endeavored to justify this trust.

We thank the Council, county society officers, individual members, and the Auxiliary for their support. We ask that they continue their efforts in the present crisis and to be prepared for further action should other dangers arise.

Respectfully submitted:

Edwin S. Hamilton, M.D., *Chairman*
Everett P. Coleman, M.D.
Edward A. Piszczek, M.D.
H. Close Hesseltine, M.D.
Kenneth H. Schnepp, M.D.
Ex-officio:
Joseph T. O'Neill, M.D.
Burtis E. Montgomery, M.D.
George F. Lull, M.D.

Medical Education and Hospitals

The Committee on Medical Education and Hospitals has held no meetings during the past year. The State Examining Board has found no necessity to request discussion or action by the

state medical society; and, consequently, no problems have been referred from the state level.

This does not mean that Illinois does not have a problem in medical education. During the past ten years the physician-population ratio has decreased in this state to a point which might soon become alarming. The number of graduates from Illinois medical schools has remained comparatively high and adequate for necessary medical services throughout the state. But many of these graduates, although originally residents of Illinois, have gone outside the state to practice or to take postgraduate training and generally do not return here to give medical service. Under the National Intern Matching Program, in which the students and the hospitals are matched according to choice, about one-half of the hospitals in Illinois received no interns within the program. This has been especially pertinent to the hospitals in the southern and central districts. It has been necessary for these institutions to obtain interns outside the matching program and also to supplement their house staff with foreign graduates. It has been estimated that at least nine out of ten of the foreign graduates return to their homelands to practice, and of the interns who are United States citizens, only a small percentage remain in the local community after serving their internships. This trend can also be observed to a less marked degree in the Cook County hospitals.

Medical services throughout the state have shown a rising contribution proportionately from physicians in the specialities. But here again, the numbers have not kept pace with the rising population, and the opportunities for obtaining essential requirements of a residency program have been lacking in the majority of hospitals outside of the Chicago Metropolitan Area. As a result, over 95 per cent of the physicians taking specialty training are located in Cook County. Moreover, the total number of resident physicians in the state has shown a gradual decrease in the past eight years. The net result of this changing situation will soon be manifested in a serious lack of medical services in Illinois, more especially in the southern and central districts.

It is obvious that an effort must be made to increase the number of graduates from the state's medical schools and to draw and retain graduates from other parts of the nation.

The medical schools are making this effort and looking into the future in their plans for supplying the necessary increase. The medical staffs and governing bodies of local hospitals, especially in the smaller cities, must give an increasing attention to improving the facilities for intern and resident training. The state medical society is definitely concerned in these matters. This committee will have to play a more active role than heretofore offering the complete assurance of the state medical society's support and cooperation with the state hospitals and the medical schools in the program to develop and maintain adequate medical services throughout the state.

Respectfully submitted,

Kenneth C. Johnston, M.D.,
Chairman
Ward Eastman, M.D.
George F. O'Brien, M.D.

Medico Legal Committee

Report not received in time for publication.

Committee on Medical Benevolence

1960 marks the twentieth year since the establishment of our Benevolence Fund as the means of bringing a little comfort and a degree of security to those former members or their widows who, through long illnesses or advanced years, are now finding themselves in need of help.

The total number of recipients for the past year is 43, one less than a year ago. The list includes 30 widows and 13 doctors who receive varying amounts to assist them in their financial difficulties. The report, necessarily, gives only the number of cases because the committee is not permitted, nor would we desire, to publicize the names of any beneficiaries. They are known only to the committee and to those who are sponsors of an individual in their home community.

Letters from the recipients express their gratitude. That fact assures us that our efforts to assist them are truly worth while. Every member of our Illinois State Medical Society can take justifiable pride in the fact that he has been a part of this program for, without the two dollars from each membership that automatically goes into the Fund, the Fund could not be perpetuated. Additional individual contributions, interest from the bonds, memorials, and a very generous donation from our Auxiliary each year, constitute the chief sources of the Fund. As of March 1, our cash balance is $33,000. Enough

money to meet the current needs of allotments is expended (no money is ever used for any other purpose). Any excess is invested in safe bonds. The total value of the bonds to date is $140,000 dollars.

While this amount might appear to be substantial, many sudden and unexpected emergencies could deplete the Fund quickly. It is wise to guarantee against such unforeseen disaster by protecting this trust fund and add to it when we can.

Three meetings were held this past year, and a final meeting is planned prior to the annual meeting in May.

The committee feels a great loss in the death of Dr. Harold Camp, not only as a valuable coworker, but as a personal friend. We recognize and give our sincere thanks to Frances Zimmer and Wanda Ross for their ever efficient and willing cooperation. Grateful are we, too, to the Woman's Auxiliary for their continued support and interest in our program.

We are presently studying the effectiveness of agency investigations of our applicants to determine if we are receiving the maximum results for the cost involved. The assistance given by officers of the local Society in the community where the applicant resides is of far more value and importance to us, we believe.

Norman L. Sheehe, M.D.
Chairman
Irving H. Neece, M.D.
F. M. Nicholson, M.D.

Medical Testimony

The Medical Testimony Committee has had no meetings during the past year; therefore there is no report to present.

Respectfully submitted,
Leo P. A. Sweeney, M.D.,
Chairman
Harry D. Nesmith, M.D.
John H. Gilmore, M.D.
Maurice D. Murfin, M.D.
Joseph H. Chivers, M.D.
Peter Rumore, M.D.
Joseph F. O'Malley, M.D.
William K. Ford, M.D.

Grievance Committee

Report not received in time for publication.

Prepayment Plans and Organizations

The House of Delegates at the May 1959 meeting elected the following members of this committee: F. Lee Strohl, M.D., Harry Mantz, M.D., and Maurice M. Hoeltgen, M.D., Chairman. The committee held its first meeting in Springfield on September 26 and made its first progress report to the Council in October, as follows:

"Inasmuch as no rules, regulations or precedents have been established, the committee immediately outlined what it considers to be its sphere of activities.

1. To serve the best interests of the patient by attempting to improve the over-all relationships of the patient, the physician and the prepayment plan.
2. It is not within the province of the committee to act in any other than an advisory capacity, and we believe that our best efforts should be directed toward supplying guidance, education and communication.
3. The committee strongly endorses the principle of free enterprise as exemplified by the private insurance companies and the Blue plans, and that they deserve the wholehearted support of the medical profession. It is our hope that the fine relationships of the past can be improved and extended.
4. The committee believes that while the highest standards of medical care must be maintained, that the most efficient utilization can be enhanced by the intelligent cooperation between the patient, the physician and the prepayment plan."

Respectfully submitted,
Maurice M. Hoeltgen, M.D.,
Chairman
F. Lee Strohl, M.D.
Harry Mantz, M.D.

REPORT OF THE EDITOR

This has been an eventful year for the Illinois Medical Journal due to the illness and death in October of Dr. Harold M. Camp, who had been editor of our publication for eighteen years. We are saddened by losing a colorful, vibrant man.

The Journal, therefore has been going through a period of reorganization, that has included transfer of Journal headquarters to Chicago. The Monmouth office, through Mrs. Jane Swanson

and Mrs. Wanda Ross, has been very cooperative in routing to us editorial notices, other journals, books, etc. until notices of changes of address can be completed.

We have been fortunate in having the continued medical editing and proofing services of Miss Marion Carey which, while on a part-time basis, has been careful and thorough. Mrs. Caroline Boeckmann has managed the editorial offices at headquarters, getting material in to meet printing deadlines, making telephone calls and writing letters to authors, checking references, and doing multitudinous tasks necessary for copy preparation.

Two new features were added to the publication during the year: 1. We ran a series of six articles "Questions and Answers on the Narcotic Act," prepared by Mr. Malachi L. Harney, superintendent of the State Division of Narcotic Control. These were sent to us by Dr. Jacob E. Reisch, Springfield.

2. In the November issue the first of a series of Reference Pages appeared. These gather together widely scattered information and are prepared to help the physician within the state find specialized facilities he may wish to utilize for his patients. The Reference Pages are perforated sheets that can be removed from each issue and kept for ready reference. Single copies from overruns are being distributed as requests are recieved from public health and industrial medical departments. We regard this as excellent public relations for the society at little more than the cost of postage.

During the current year the Journal has published 80 original articles, 11 of these a continuation of the series on the heart by authors throughout the country. Copy is supplied through the cooperation of the Chicago Heart Association, which mails reprints to all its physician members and sends 100 copies to each author for his distribution.

A continuing monthly feature has been the Clinical-Surgical Conference from Cook County Hospital, moderated and carefully reported by Dr. Robert J. Freeark.

In addition, a total of 95 editorials have been published; 19 of these were signed editorials on scientific subjects by recognized authorities.

The Editor's Desk, made up of information that might not otherwise come to the attention of most physicians, has proved a popular feature of our Journal. It has contained approximately 300 items of news and comment on timely scientific, medical, and related subjects. A studied effort was made to acquaint the reader with, in our judgment, some of the better new pharmaceutical products and to point up the weaknesses of claims for certain others. Many of the pointed paragraphs given here have been reprinted by other medical publications.

In line with the society's interest in the aging population, we have been publishing a series of articles on this subject, through the cooperative assistance of Dr. Edward W. Cannady of the Committee on Aging.

We have continued reporting the minutes of the Council meetings and, in accordance with directive, have published the proceedings of the Special Meeting of the House of Delegates held in December.

We wish to express our gratitude to Mrs Kathryn Simmons for preparing the death notices and listing lectures arranged through th ISMS; to Mr. John Mirt for his PR pages and Correspondence reports; and to members of the various committees of the medical society for submitting material for publication from time to time.

Mr. Malley reports that although the annual audit is not complete (February 29), it is reasonable to expect that this will be the nineteenth consecutive year the Journal has increased its advertising billing over the previous year. Contributing to this record was the November issue with the largest billing in our history. This exceeded the previous high (November, 1957) by $3,500.

Increased billing reflects, in part, the growth of the pharmaceutical industry and its introduction of new products. Your Journal has, for example, added six new display advertisers during the past year. In the same period three advertisers were found unacceptable upon preliminary investigation; a word of thanks is extended to those who helped in these investigations.

Current questioning of pharmaceutical manufacturers' advertising appropriations make it unwise to assess future advertising revenue, but certainly an informative journal will always be of value. We suggest again a 5 per cent increase in our rates to meet increased publication costs.

There have been some changes in personnel to stabilize the staff. At the first of the year, as you

know, my status as acting editor changed to editor. With the employment of Miss Martha Dana as assistant editor, beginning in February, we now have full-time professional editorial management.

Restyling the Journal, begun modestly in January with changing the cover color to blue, is continuing. Much can be done typographically to improve not only the appearance of the Journal but also its readability.

We are planning to tap the large reservoir of excellent, timely, scientific information presented weekly by speciality societies in Chicago and thus improve the caliber of published material.

In my opinion, it is in this area we must concentrate in the future to raise the scientific standards of our Journal.

Respectfully submitted,

T. R. Van Dellen, M.D.
Editor

REPORT OF THE EDITORIAL BOARD

In anticipation of and pursuant with the action of the Council at its meeting on January 31, 1960, the Editorial Board of the Illinois Medical Journal has remained on a "stand-by" status. It will continue to do so until the reorganization program of the Journal has been determined.

Edwin F. Hirsch, *Chairman*
James H. Hutton
John R. Wolff
Frederick H. Falls
Edward F. Webb
Arkell M. Vaughn
Samuel A. Levinson
Jacob E. Reisch
Francis L. Lederer
Robert D. Mussey

JOURNAL COMMITTEE

During the past year the activity of the Journal Committee has been considerably decreased due to the reorganization taking place in the Illinois State Medical Society and the change in editorship occasioned by the death of Dr. Harold M. Camp.

A meeting was held September 15, 1959, for the primary purpose of selecting a publisher for 1960. After reviewing the experience and relative cost of printing the Journal as detailed in the bids secured in 1956, and on the statement from The Wayside Press that they would continue to publish the Journal in 1960 at no increase in cost, the committee recommended that this firm be named publisher for 1960. This was approved by the Council.

Matters concerning improvements in format, style, type, cover, advertising page numbering, and other physical attributes of the Journal were discussed but action deferred pending the development of a more stable staff set-up.

Despite no additional formal meetings, the committee has continued to function in various ways such as the review of new advertisements submitted for the Journal. This has beeen accomplished by mail and telephone.

On October 26-27, 1959, your chairman attended a two-day meeting of the State Medical Journal Advertising Bureau held in Chicago. This meeting was very educational as to the methods, policies, contents, and problems among the 33 state medical journals this organization represents.

The chairman of this committee is deply appreciative of the dedicated interests of the members of this committee who are unanimously most anxious to give of their time and talents to making the Illinois Medical Journal the nation's most outstanding State Medical Journal.

Respectfully submitted,

Jacob E. Reisch, M.D., *Chairman*
W. H. Palmer, M. D.
Albert VanderKloot, M. D.
Paul P. Youngberg, M. D.
Raleigh C. Oldfield, M. D.
Joseph Sodaro, M. D.
Joseph T. O'Neill, M. D.

REPORTS OF ADVISORY COMMITTEES

Dependent Medical Care Program

The Medicare Program for Dependents of Uniformed Service Personnel, which was curtailed on October 1, 1958, has been revised and certain benefits restored as of January 1, 1960.

Under these program revisions all surgery which is medically indicated for functional improvement, and performed during hospitalization, will be authorized at government expense. However, surgical services desired or requested by the patient, or which are not medically indicated, are not authorized for payment. In other

words, surgery which will improve the patient's well being, or as a result of which procedures might prevent further progression, or untoward changes, is authorized.

Surgery of the ears, eyes, mouth, surgery for skeleton defects, scars, etc., may be authorized when it can be substantiated that definite improvement may occur, or that such surgery is necessary to prevent further deterioration.

Cosmetic surgery, such as reconstruction of ears, or congenital defects, removal of tattoos, surgery to correct a state of infertility or sterility will not be authorized for payment under any circumstances.

Acute emotional disorders may again be treated in the hospital for a period not to exceed 21 days. Pre- and post-hospitalization tests and procedures required for the proper management of bodily injuries and surgical procedures for which the patient is hospitalized are again authorized. Out-patient office visits or physical examinations are not authorized for payment.

Payment is authorized for bodily injuries when a patient is not hospitalized for the treatment of fractures, dislocations, lacerations, and other wounds. The patient is required to pay the first $15.00 for each different cause or accident for which treatment is rendered. Medical care in the hospital for these dependents is again authorized as was the case before curtailment of the program.

If the patient was admitted to a hospital before January 1, 1960, for care authorized under the restored program, and was still there on January 1, payment will be made for the current uninterrupted period of hospitalization. Also payment will be made for pre- and post-hospitalization diagnostic tests if procedures are authorized for the proper management of the injury, or surgery for which the patient was hospitalized.

From January 1, 1959, to December 31, 1959, 2,394 physicians provided care for 6,193 patients and received the total sum of $578,904.55 for this care. Of these cases, 3,994 were obstetrical, including miscarriages, incomplete abortions and isolated antepartum care; 69 physicians received pay for care of prematures; 328 for normal newborn care; 14 for complete Rh transfusions; 959 for general medical care, including infants and children; 95 for fractures; 94 for other bodily injury; 122 for gynecological surgery; 222 for general surgery; and 296 physicians were paid for anesthesia services. Inasmuch as there is still considerable delay in the submission of claims, these figures may not be entirely realistic or up to date.

It will be recalled by the House of Delegates that the Council of the Illinois State Medical Society renewed its contract under protest due to the restrictions that went into effect on October 1, 1958. The removal of most of these restrictions is gratifying and substantiates the objection of the Council to the change in the program at that time. The contract has been renewed for another year by the Council of the state society without material change.

General Wergeland, for the Department of Defense, and the Illinois Medical Service, acting as fiscal administrator for this program, have been most co-operative in the administration of this project.

Respectfully submitted,

Percy E. Hopkins, M.D.,
Chairman
Edwin S. Hamilton, M.D.
Joseph T. O'Neill, M. D.
Walter C. Bornemeier, M.D.
Norris Brookens, M.D.
J. Stuart Moffatt, M.D.

Illinois Public Aid Commission

In the past year this committee has been confronted with a wide variety of problems, many of which are new because of the changing times and the changing methods of the practice of medicine, many of which fit into old patterns. These problems have been met in the manner which seemed most advisable to this committee, on occasion with the assistance and consultations of the various subcommittees and other sources.

This is the first year for the new increased fee schedule, and it is our opinion that it has helped relieve some of the problems. This committee is still ceaselessly working for more increases in payments to physicians, and it believes that the Illinois Public Aid Commission is in sympathy with these increases but is unfortunately tied down by limited budget allotments. There are many individual fields in which we feel there should be increases, as well as a general across-the-board increase.

Another field in which there have been changes made this year is drugs prescribed and the limitations there of. The Illinois Public Aid Com-

mission has increased the financial limitation on these drugs to $5.00 per pint, pound or 100. And, after due consideration by this committee, it was felt that there would be no further restrictions put on drugs by this committee, and that any exceptions to this price limitation should be handled by the county medical advisory committees, with the understanding that the state committee was ready to give aid or consultation in difficult cases.

The work of the medical advisory committees have been such in this past year that more and more decentralization is occurring; the county medical advisory committees are being asked to handle more of the problems on a local level whenever possible. This has worked particularly well, and it is the feeling of the state committee that this not only is a good thing from the view point of more efficiently handling the work but of public relations with the individual doctors of the state and county medical advisory committees. We are pleased that the recommendation was made to this committee by the House of Delegates at its meeting two years ago.

One other change of particular value to our committee was the hiring of Dr. E. Holmblad as medical director of the Illinois Public Aid Commission. Dr. Holmblad has been of great assistance to us in handling many of the routine problems formerly handled by the state committee. We wish to publicly announce our gratitude to Dr. Holmblad for his excellent work and his cooperation with the State Medical Society.

As in the past, we have had our meetings at regular intervals and have continued the practice of inviting to them chairman and members of the county medical advisory committees. This promotes their better understanding of problems the committee handles for them arising from their work with the Illinois Public Aid Commission.

Respectfully submitted

J. W. Compton, *Chairman*
B. E. Montgomery, *Co-Chairman*
H. English
H. McGavran
R. Heerens
W. Schowengerdt
F. Tworoger
W. Whiting

Illinois Medical Assistants Association

The Illinois Medical Assistants Association, a group of medical assistants organized for self improvement and dedicated to their employers and the support of organized medicine, has made material advancement in the past few years. Although they have not been accepted by some county medical societies, they have proven themselves, where organized and accepted, to be worthy of the recognition that this society has granted them.

Their efforts for self improvement follow the line of educational panels and encouragement of formal schooling for those of their members who wish them. No penalty is placed on any member who does not, or cannot, avail himself of these opportunities. Through general educational meetings, all members are encouraged to progress in their field. Their efforts in public relations and legislation have followed closely our own society plans and have been helpful and effective.

The officers of this group have often sought counsel and are most anxious to extend their energies in lines acceptable to the medical profession. More local groups should be encouraged by the local county medical societies.

Respectfully submitted,
Carl E. Clark, M. D.,
Chairman

Governmental Medical Services

AMERICAN LEGION (ILLINOIS DIVISION)

The members of the Advisory Committee to Governmental Medical Services — Sub-Committee on American Legion did not meet as a committee this past year.

There was no specific need for calling a meeting, but the members were on "stand-by" call for their services. Therefore, there will be no report to the House of Delegates.

Norman L. Sheehe, M.D.
James A. Weatherly, M.D.
Walter C. Bornemier, M.D.
Jacob E. Reisch, M.D.
J. O. Firth, M.D.

CIVIL DEFENSE

This Committee again this year has found its work well assisted by the literature distributed from the Federal Civil Defense Administration National Headquarters. Policies for organization

of defense work and the actual participation in preparations were efficiently described for physicians in the pamphlets forwarded to the Directors of Civil Defense in the various counties of the state.

As directed by the Council, the Sixth Regional Meeting of the AMA Committee on Disaster Medical Care in Chicago, January 23, 1960, and the 10th Conference of the County Medical Societies Civil Defense were attended by some members of the committee. They reported that both these conferences were quite worth while and presented the needs as to type of work in which our committee should engage. The thermonuclear aspect of this activity is becoming far more interesting because it appears far more likely to involve even rural communities far removed from "target areas."

The relationship which the ISMS and its component county and branch societies should maintain with governmental agencies was a more or less unknown until early this year. Governor Stratton, in naming the successor to the late Dr. Roland R. Cross in the state department of health, has taken action quite definitely establishing the relationship of the state department of health to the other agencies in civil defense and disaster planning. This is indeed a decidely helpful action to the medical category on the part of the governor.

To attain interest of the physicians in civil defense and disaster planning remains indeed quite a problem. Some of our local medical societies have in charge of this portion of their program members who have become interested in it because of acquaintance with the director appointed for their county and through him having access to a wide volume of literature from the national office. The establishment of good relationship and frequent discussions between the local medical civil defense committee and their county director (a layman) will clear up much misunderstanding and will accentuate their efforts in the planning for disaster.

The State of Illinois is by no means in the forefront of other states in preparedness for disaster. This is true financially and also in matter of personnel.

A parcel of our members who have given considerable study and planning to civil defense is the "Flying Physicians." This organization can be of very great help and can be activated most speedily if needed. Even though their number is small, they have all shown interest and are well informed on to how to act.

An activity that has been effected this year is the "Illinois State Plan for the Prepositioning of Civil Defense Emergency Hospitals." This has been done by the Illinois Department of Public Health in its Bureau of Hospitals. Fourteen of these are already existing and 102 are in the programmed list. This work was accomplished for the state in the offices of the department of health.

A summary of food and drink sufficient for a two weeks' stay in a bomb shelter was prepared by one of our committee members and has been given wide distribution. This contained quantities for a family of five.

A survey of what has been performed in the various county and branch societies of our state shows activity quite above that of one year ago.

Of course, all "recognized" or accredited hospitals have, on paper at least, arranged a plan for action in emergencies of sizeable nature. Many of these during 1959 had trial runs of their plan. In many unit societies this plan has been adopted as their plan and justifiably so because of the small number of their medical men available.

Most of our units are negligent in their arrangement for instruction of dentists, technicians, etc., to become valuable assistants to the medical men in disasters. A very few societies have attempted a program along this line. It is too soon and they are too few to give us a tangible format at this time for this necessary part of the work which each of our societies must set up and make function. This is a major activity which your committee must initiate and in which successful results must be accomplished this coming year.

The momentum of civil defense and disaster planning will gain in its scope and degree this coming year.

"Almost any Civil Defense program, if pursued vigorously, would be a reminder to the Russians that the United States will not submit to thermonuclear blackmail—that it is prepared, should the need arise, to accept the possibility of a big war with big bombs. If this point were brought home to the Russians, then Civil De-

fense could itself serve to make that war less likely."

Respectfully submitted,
Charles P. Blair, M. D., *Chairman*
Earl H. Blair, M. D.
C. L. Carter, M. D.
Kenneth H. Schnepp, M. D.
Philip Lewin, M. D.
Gilbert Edwards, M. D.
Chas. L. Maxwell, M. D.

CORONER'S COMMITTEE

The committee concerned with improving the quality of the medical examinations for the coroners of the down-state counties was active during the last session of the General Assembly in bringing support to and passage of Senate Bill 159, which authorized the department of health to establish and operate toxicological laboratories, including toxicological services for the medical examinations of cases referred for investigation to the down-state coroners. An amount of $200,000 was appropriated for this purpose for a laboratory at Springfield to service the southern tier of counties and another laboratory in the branch laboratories in Chicago to service the northern tier of counties. S.B. 159 was passed by the Senate without a dissenting vote, 49 voting; and by the House, 157 voting affirmatively, 2 voting against the bill and 5 voting present. Although the Coroners' Committee of the State Medical Society did not participate as such in the activities to improve the quality of the medical examinations of the cases referred to the Coroner of Cook County, several members of the state committee participated in the program now in progress in Cook County for a quality Institute of Forensic Pathology for the coroner of Cook County.

Organized medicine of the state and of Cook County can look with pride upon the results achieved and those in progress toward improving the quality of the medical examination of cases referred to all of the county coroners of the State of Illinois.

Edwin F. Hirsch, *Chairman*
Samuel A. Levinson
Dennis B. Dorsey
C. Paul White
Frederick C. Bauer, Jr.
Grant Johnson

ADVISORY COMMITTEE TO SELECTIVE SERVICE

Though the doctors' draft law continues in effect, the supply far exceeds the demand, and there is no need to draft physicians at the present time. There has been very little work for this committee, only an occasional call from an interested or draft eligible physician.

The death of our faithful and most helpful member, Dr. Roland Cross, has been a great loss. He has been replaced by Dr. L. L. Fatherree, the newly appointed director of public health.

In an attempt to keep the local committees intact and ready for any emergency, replacements have been made in the various county committees when vacancies have arisen as a result of advanced age, death, or members moving from the area.

It continues to be very interesting to be of help to the embryo physician with his possible military problems.

Carl F. Steinhoff, *Chairman*
L. P. A. Sweeney
F. Garm Norbury
James Majorakis

COMMITTEE ON VETERANS ADMINISTRATION

From the reports of the AMA Council on Federal Medical Services down to the local committees relative to service to veterans, it is the firm opinion that medical services to the non-service connected veteran be curtailed. With this object in view, many conferences at high levels have been held with little change in policy.

The AMA Council on Federal Medical Services has made the recommendation that as long as non-service connected care is continued, the Veterans Administration establish formal priorities for admission of such cases, whereby first consideration will be given to those veterans with financially disastrous, chronic, long term illnesses, and those who require intensive hospital care and other costly treatment. Lowest priority would go to those with acute short-term illnesses which cause only temporary financial inconvenience, and particularly where much of the cost is covered by insurance or prepayment plans.

It is urged that we actively assist in obtaining needed care for those veterans with financial catastrophic disabilities; also that we assist veteran patients in determining the probable cost and their ability to pay.

In 1958 the House of Delegates of the AMA adopted Resolution No. 30 recommending a suggestion to the Deans Committees that they restrict their activities to Veterans Administration Hospitals, admitting only patients with service connected disabilities. Upon further study this was considered impracticable because it would eliminate the Deans Committee residency and internship program due to lack of variety of cases available for education and research. It is likewise recognized that if affiliation with medical schools were terminated, the quality of care given to veteran patients would be threatened. This latter statement is controversial.

It is the recommendation of the Council on Medical Service of the AMA that veterans requiring office, home, hospital, nursing home, or convalescent care for any service connected disability should have the right to choose between care by a private physician in a private facility at Federal expense or treatment in Veteran Administration facilities rather than that this decision should be as at present the prerogative of the Veterans Administration officials.

The Veterans Research Hospital of 333 E. Huron Street was visited by the chairman, and he was most cordially received. A few statistics may be interesting: The total applications for hospitalization in 1959 were 9,704; of these 5,271 were rejected. Total patient days was 169,285. Average length of stay—medical, 20 days; surgical, 21 days. Deaths—351. Autopsies—242. Total clinical laboratory tests—249,912. A total of 727 patients received 3,195 units of whole blood.

This committee recognizes the complexities and political implications of the problem of veterans' care as well as the pressure applied by various veteran organizations and hopes that by continued activity we may some day fully obtain our objective of adequate care for the service connected disabled veteran.

Carl F. Steinhoff, *Chairman*
Percy Hopkins
F. Lee Stone
L. P. A. Sweeney
Ivar E. Dolph

Woman's Auxiliary

The Advisory Committee to the Woman's Auxiliary has not been faced with any serious problems during the past year. This is due to the fact that the officers and executive committee of the Auxiliary have been untiring in their efforts to continue the development of an enthusiastic and self-sustaining organization.

The Auxiliary has been very active. Projects which have had a high priority rating are Community Services, Legislation, A.M.E.F., Civil Defense. Words alone cannot express the interest and enthusiasm with which the Auxiliary has successfully accomplished the realization of these projects.

At a January meeting of the Advisory Committee with Mrs. Van Prohaska and her Executive Committee, the annual budget was reviewed and it was learned that the Auxiliary would not require any financial help from the state society for the year 1960-1961. This is certainly a great step forward in being self sustaining. Also at this meeting, assistance of the Auxiliary for the annual dinner was discussed. As in previous years, the Auxiliary will again help to make the annual dinner a wonderful success.

The Illinois State Medical Society wishes to thank the Auxiliary for the very, very many fine contributions it has made during the past year, and the state society urges the component county societies to register a vote of thanks for the work that their auxiliaries have accomplished.

Respectfully submitted,

Ralph N. Redmond, M.D., *Chairman*
Walter C. Bornemeier, M.D.
C. Elliott Bell, M.D.
Harry J. Dooley, M.D.
Bernard J. Klein, M.D.

Woman's Auxiliary

My year as president of the Woman's Auxiliary to the Illinois State Medical Society is drawing to a close. The opportunity to serve in this capacity has been a challenge that could not have been met without the indefatigable cooperation and support of my board, the understanding and moral support of the Illinois State Medical Society, and the wise and patient counseling of the members of the Advisory Committee.

This has been a year of decision and change for the auxiliary. We are now functioning under a self-supporting budget and hope that in the future we will not need to come to you for funds; but be assured that we will always come for your generous approval of our projects, your guidance

in our endeavors and your welcome hand of friendship.

This year Illinois, with the approval of our Advisory Committee, did not have a Fall Conference. Instead the board brought the Fall Conference to the membership in a series of ten one-day district meetings. This significant adventure in learning and understanding has done much to strengthen the rapport between members and board, and more important, approximately 750 members have been actively involved in planning and participation instead of the 115 the previous year. Funds set aside in our budget for conference were used for board travel to these meetings.

Each district meeting was as unique in plan and program as the councilor chairing it. Various techniques—round tables, skits, talks, program clinics, and question and answer periods—were used to bring the purpose and program of the auxiliary to the members. The board served as resource persons, speakers, or in any other requested capacity.

If these district meetings have opened the door to a few new ideas, if they have shown the member what direction our program is taking, if the auxiliary has more appeal to members after attending a meeting, then, they have served their purpose, and Illinois should go forward on the crest of enthusiasm created by these friendly gatherings.

We are proud to announce the organization of a new auxiliary in McHenry County. We now have 41 auxiliaries in 47 of the 91 counties with medical societies. Through you, the delegates to the state convention, we invite wives of all members of the Illinois State Medical Society to join us either as members-at-large or as members of newly created auxiliaries. Membership in the auxiliary means that your wife will join other doctors' wives in the community, state, and nation in discovering the pleasure and satisfaction of doing something for the profession.

Our program throughout the state has been geared to our national theme: "Accept Individual Responsibility for Better Community Health." The counties—large and small—have wholeheartedly accepted this responsibility to the best of their ability.

We have "lived" community service by actively participating in practically every phase of community and health activity. At the community level we have become interested in the whole question of the care of the aging. A member of the board attended the Conference on Aging sponsored by the American Medical Association held in Kansas City.

Our major activity in the field of legislation has been our unwavering work against the Forand Bill. Many, many letters and resolutions have been written to our Congressmen, Representatives, and members of the Ways and Means Committee. Meetings were held with these legislators before Congress convened in January. We contacted lay groups and offered them materials, programs, and speakers on the subject. Publicity was given to our work in the local press. The most recent undertaking was the Forand Bill Exhibit presented at the clinical conference in Chicago where more than 800 doctors from 13 states stopped and wrote their letters on the spot. Members of the auxiliary, cooperating with the medical society, addressed and mailed these letters. The results were most gratifying!

There has been an increased interest in both the American Medical Education Fund and our own state Benevolence Fund. Through various activities—benefits, sales, memorials, use of sympathy and in-appreciation cards, and direct gifts—your auxiliary has worked diligently raising money for these major projects.

Our Recruitment Program has been broadened to include careers allied to medicine and is no longer limited to nurse recruitment. However, scholarships and loans at the county level have been appropriated to nursing, and today we have about 65 students in training under this program. The work done at the local level with high-school students through Future Nurses Clubs, Allied Careers Clubs and 4-H groups is a heart-warming example of the auxiliaries assuming "individual responsibility for better community health."

This year we have tried to further good mental health through education. We have offered our program to clubs, P.T.A.'s and church groups. As individuals, we have given countless hours of volunteer service to state mental hospitals and local mental health organizations.

Civil defense and safety are with us to stay. In both these areas we again have emphasized education and individual responsibility. Home Nursing, First Aid, and preparedness in case of emergencies are an integral part of civil defense.

Safety in the home, on the highway, and on the farm has been our goal through effective education.

We are proud and happy to be included once again in the plans for the annual dinner at convention. We deem it a privilge and a pleasure to work FOR YOU and WITH YOU.

Respectfully submitted,

Mrs. John Van Prohaska, *President*

Committee on Aging

The Committee on Aging has continued an active program during the past year. It continued to be concerned with adequate voluntary methods for financing the medical care of the aged. On August 20, 1959, a meeting was held with representatives of the Medical-Surgical Plan of Illinois Medical Service (Chicago) and the Medical-Surgical Service of Illinois (Rockford) regarding the urgent need for making available Blue Cross-Blue Shield plans to new individual subscribers age 65 and over. During recent months the Rockford group has announced a plan for hospital, medical, and surgical benefits available to new individual subscribers 60 years of age and over. The proposed low-cost Blue Shield plan for people with low incomes and limited assets was announced recently by the officers of the Illinois State Medical Society. The Blue Cross Plan of Hospital Service Corporation (Chicago) has announced that special Blue Cross-Blue Shield plans will be available soon to individuals over 65.

Members of the committee are participating actively in Illinois preparations for the White House Conference on Aging to be held in Washington, D.C., January 9-14, 1961. The Illinois State Advisory Council on the Improvement of Economic and Social Status of Older People, established by the 1959 session of the Illinois General Assembly, has the authority to proceed with plans for the White House Conference on Aging. The law establishing the Advisory Council provides that it shall have the use and facilities and staff of the Illinois Public Aid Commission. Hence, the administrative arm of the council is the Illinois Public Aid Commission. The chairman of the Committee on Aging is a member of the Advisory Council. Dr. Otto L. Bettag, director of the State Department of Public Welfare, and Dr. Leroy L. Fatherree, director of the State Department of Public Welfare, serve as ex-officio members of this council. Dr. Henry Ricketts is serving on the state Research Committee, which was formed to gather and analyze basic information to be made available to regional and other groups. Dr. P. V. Dilts attended the Leadership Training Institute for the White House Conference on Aging in Ann Arbor, Michigan, June 24-26, 1959.

A special report on Illinois plans for preparation for the White House Conference was submitted to the members of the Committee on Aging, the Council of the Illinois State Medical Society, and each county medical society. Every county medical society, the Women's Auxiliary to the Illinois State Medical Society, the county advisory committees to the Illinois Public Aid Commission, and the county medical societies' Committees on Aging were alerted to be prepared to participate actively at county, regional, and state levels in the Illinois preparations for the White House Conference. Further reports will be distributed as pertinent information becomes available.

Plans for Illinois preparation include meetings at county (April), regional (May), and state (September) levels. The county meetings will be open meetings called by the County Welfare Service Committee (IPAC) or local planning groups on aging to which the general public will be invited. It is anticipated that attendance at regional and state meetings will be by invitation. The final report to be submitted by Illinois will be drafted from deliberations and recommendations following these conferences. Illinois will be represented at the White House Conference by one hundred delegates. Physical and mental health including financing medical care of the aged will probably be the most controversial subject to be discussed at county, regional, state, and national levels.

On Sunday, September 27, 1959, a conference on aging was co-sponsored by the Committee on Aging and the Committee on the Secretaries' Conference. The purpose of the conference was to stimulate interest of county medical societies and to encourage the development of programs at the local level. Numerous subjects were discussed including surveys of the problems and needs of the aged, early detection and prevention of chronic illness, nursing home care, rehabilitation of the chronically ill aged, home care pro-

grams, the program of the Chicago Central Service for the Chronically Ill, methods of financing medical care of the aged and the AMA Six Point Program on Aging. Participants included physicians and guests nationally known in the field of aging.

The Illinois Joint Council to Improve the Health Care of the Aged was formed in May, 1959. Members include the Illinois State Medical Society, the Illinois Dental Association, the Illinois Hospital Association, and the Illinois Nursing Home Association. The purposes as stated in the constitution are to cooperate with the National Joint Council to Improve the Health Care of the Aged, to coordinate activities of the member organizations related to the care of the aged in Illinois, to study by all means available the health problems of the aged population in Illinois, to cooperate with other agencies having a similar interest either voluntary or governmental, and to disseminate information on health care of the aged to the public. The constitution of the new organization has been approved by the Council of the Illinois State Medical Society. Representatives from the Illinois State Medical Society are Drs. Mallory, Strohl, and Cannady (chairman of the Advisory Council). Drs. Dilts, Lull, and O'Neill have also attended meetings. The committee was represented at the First National Conference of the Joint Council to Improve the Health Care of the Aged in Washington, D.C., on June 12-13, 1959.

The Committee on Aging is sponsoring the publication of a series of articles on aging in the Illinois Medical Journal. Articles either published or ready for publication include:

Medicine's Approach to the Problems of Aging
Illinois Department of Public Health's Responsibilities and Programs Related to the Aging Population
Our Aging Population and the Problem of Chronic Illness in Chicago
Prevention and Early Detection of Chronic Illness in the Aged
Nursing Home Problems
Home Care Programs
Rehabilitation of the Chronically Ill Aged
Services for Aging and Rehabilitation in the Illinois Public Aid Commission

The articles have been contributed by members of the Committee on Aging or by invited guests.

The Committee on Aging has engaged in other miscellaneous activities. At the request of the chairman of the Council, a program regarding a nursing home classification project was studied. The American Nursing Home Association requested the Illinois State Medical Society to give approval to a research study to evaluate a nursing home classification project. The ultimate aim of the project was the development of a voluntary accreditation program for nursing homes and related facilities. The project would be conducted under direction of the American Nursing Home Association with the cooperation of the Illinois Nursing Home Association and the Indiana Association of Licensed Nursing Homes. During a three-year pilot program facilities selected for study would be located in Illinois and Indiana. The Council of the Illinois State Medical Society has approved in principle such a project.

The American Medical Association and five state medical societies, including Illinois, co-sponsored a Regional Conference on Aging in Kansas City in November. Dr. Joseph O'Neill, president of the Illinois State Medical Society, presided at the opening session. Other participants included Drs. Strohl and Cannady.

Dr. Ruth Church, deputy director of the Illinois Department of Public Health, invited the Committee on Aging to co-sponsor a symposium on the care of the stroke patient. After approval of the Council, the committee accepted the invitation. Dr. Caesar Portes is representing the committee in planning the symposium, which is expected to be held on May 25 during the annual meeting of the Illinois State Medical Society.

The program of the Committee on Aging was presented before the Commission on Aging on January 18. The Commission on Aging was established by the legislature and is composed of ten members of the legislature and five public members appointed by the governor.

The committee will be represented at the National Health Council's 1960 National Health Forum on "Positive Health in Older People," in Miami Beach, March 14-17.

A questionnaire was sent to every county medical society requesting information regarding their program on aging. It is anticipated that a supplementary report regarding the findings of the survey will be made to the House of Delegates.

During the next year it seems apparent that the program of the Committee on Aging should emphasize two subjects: the Illinois preparations for the White House Conference on Aging and further encouragement of the development of programs on aging by county medical societies.

The death of Dr. Roland Cross removed one of the committee's active and cooperative members. However, we wish to acknowledge the assistance of Dr. Ruth Church, deputy director of the Illinois Department of Public Health, who met with us on several occasions during the year.

Respectfully submitted,
Edward W. Cannady, M.D.,
Chairman.
Preston V. Dilts, M. D.
Everett P. Coleman, M. D.
Henry L. Schmitz, M. D.
E. L. Strohl, M. D.
Henry T. Ricketts, M. D.
Caesar Portes, M. D.
Joseph R. Mallory, M. D.

Liaison Committee To The Illinois Bar Association

The Liaison Committee made contact with the president of the Illinois State Bar Association, Mr. Gerald C. Snyder of Waukegan. Mr. Snyder was gratified to know of the formation of such a committee by the Illinois State Medical Society and advised us by letter that this fact would be discussed with the Committee on Administration of the Illinois State Bar Association and subsequent meetings arranged.

Your liaison committee has also been active with the Committee on Impartial Medical Testimony and has made contact with several judges of Illinois to achieve the goals of our society.

Respectfully submitted,
Newton DuPuy, M.D.
Arthur F. Goodyear, M.D.
William E. Adams

Birth Certificates

The Committee on Birth Certificates met in Springfield with representatives of the Bureau of Vital Statistics of the State of Illinois. The better part of a day was spent in drawing up new birth certificate forms. These embody several changes which we feel will meet with the approval of members of the Illinois State Medical Society. The certificates have been approved by the Council of the society and should be in use in the not-too-distant future. A subsequent report will be made at the meeting of the Illinois State Medical Society in May, 1960.

The Committee on Medical Service and Public Relations will present legislation, suggested by our committee, at the next session of the Illinois Legislature which, if passed, will serve to restrict the privileged and personal information of the birth records.

Respectfully submitted,
Newton DuPuy, M. D.
H. Close Hesseltine, M. D.
Jacob E. Reisch, M. D.

The Committee on Disease Control

The Council of the Illinois State Medical Society, through the "Committee on Committees", has recommended and approved that the following committees be combined and be known as The Committee on Disease Control, and that the respective units operate as subcommittees: 1. The Committee on Cancer, 2. The Committee on Cardiovascular Disease, 3. The Committee on Tuberculosis, 4. The Committee on Mental Health.

This is the second year that this Committee on Disease Control has functioned. During the past year no formal meetings were needed or requested by the subcommittee chairmen. However, many of the subcommittee chairmen have had informal conferences with the chairman. Resolutions were submitted through the Committee on Cancer. Numerous meetings were attended at the American Cancer Society offices. Correspondence was requested and provided for the Committee on Cardiovascular Disease.

This new Committee on Disease Control realizes that its function and duties become more valuable as the subcommittee chairmen request its integrated experiences and exchange of thoughts.

James D. Majarakis, M.D., *Chairman*

COMMITTEE ON CARDIOVASCULAR DISEASE

The Committee on Cardiovascular Disease will meet before the May, 1960 meeting of the House of Delegates. This committee has not been functioning for a number of years, but was reactivated for 1959-60. For many years the members have been active in the work of the Illinois Heart Association and Chicago Heart Association, whose work closely parallels the functions

and purposes of a State Cardiovascular Committee. Therefore, to merely duplicate the work that the heart associations are already doing would be wasted effort except in cases where either group might need the help of the other to carry out a particular program.

A program that does seem to merit our studied interest is that of home care. A successful program is functioning in Peoria through the coordinating efforts of the Visiting Nurses Association. A start on a similar program is being studied in St. Clair County and will be partially subsidized by the St. Clair County Chapter of the Illinois Heart Association.

If, through our efforts, we are able to further this work and to help in establishing locally functioning assistance in many areas for the aged group suffering from cardiovascular disease, at least a part of our purpose will have been realized.

Respectfully submitted,

Arnold S. Moe, *Chairman*

CANCER CONTROL

Report of the meeting of the Illinois State Medical Society's Cancer Advisory Committee, which was called at the request of Dr. Roland R. Cross and was held in conjunction with the Illinois Department of Public Health Cancer Advisory Committee.

Considerable discussion was held on the proposal of the Department of Public Health for utilization of funds allocated to the department with the appropriation of Senate Bill 1010.

Under the provisions of this bill, the Illinois Department of Public Health is authorized to assist full-time local health departments in detecting cancer in the early stages; in stimulating prompt treatment when needed, and in providing home visiting nursing services and similar services aimed at the prevention and control of cancer. The sum of $200,000 is appropriated to the department for carrying out the provisions of this act for the biennium. The Department of Public Health proposes that every full-time health department be allocated a stipulated amount of money that could be used for payment of Papanicolaou testing for early detection of cancer of the cervix in low income groups and recipients of public welfare agencies. The exact means of doing this is to be worked out on a local level, with the understanding also that, where this type of program is not feasible in the local community, the local health department may submit a plan and a proposed budget for a project related to cancer that can be reviewed by the State Department of Public Health for consideration. It was agreed by the committee that it should be stipulated that, if the Papanicolaou testing program was to be done, the program should not approve payment for reading of slides other than by a laboratory supervised by a pathologist.

It was also agreed by the committee that local health departments should not subsidize hospital cancer clinics, per se, but would be permitted to pay for diagnostic procedures necessary to clarify the diagnosis of a suspected malignancy found by a community screening program, provided no other public or private funds are available to pay for it.

The Committee also agreed that the department should discontinue providing "free" tissue examinations for diagnosis of cancer except as part of services needed for diagnosis under provisions of the statement preceding.

The Illinois Department of Public Health requested that the committee study and advise the department regarding the need or desirability of arranging to provide in the department laboratories facilities for the screening of Papanicolaou smears for the early detection of cancer. The department is now being requested to provide this service in some areas.

Respectfully submitted,

Caesar Portes, M.D.,
Chairman
Warren H. Cole
Edwin F. Hirsch
Russell M. Jensen
Franklin J. Moore
Thomas Sellett
Augusta Webster
Arthur F. Goodyear
Wilson R. Scott
W. E. Adams

MENTAL HEALTH

One regularly scheduled meeting of the subcommittee was held. This again was at the time of the AMA Sixth Annual Conference of Mental Health Representatives of State Medical Associations November 20-21, 1959. Illinois was fortunate again that the gracious invitation of the

Council on Mental Health of the AMA included our entire committee. Other state representatives have mentioned that enviously. The committee is grateful to the AMA and our own Council for this opportunity. A report of this meeting was made to the Council.

The committee meeting during the noon luncheon brought forth several recommendations. Dr. Hugh T. Carmichael of the AMA Council on Mental Health referred to conversation with President Elect H. Close Hesseltine regarding a Section in Neuropsychiatry for the annual meeting. The committee recommended this in its report. So far, we have heard of no action.

Another recommendation made heretofore for the 1958 election was that the Council take a positive affirmative stand for the proposed bond issue in the 1960 election. This, or something else, caused the Council to appoint a special committee to look into this and other matters. The special committee recommended approval. The Council concurred. Cheers! The Council referred to the committee another item, that of making representation to Governor Stratton and Dr. Otto Bettag regarding release of funds for construction in Southern Illinois of an institution for patients with mental retardation. Such representations have been made by the chairman. (This is election year.)

Dr. Bettag asked the Council to submit names of physicians for the State Commission on Mental Retardation and the State Commission on Mental Illness. The Council asked the committee to submit a list which was transmitted to Dr. Bettag.

Committee members continue, along with many others, to take an active part in mental health activities. Professional participation, civic group coordinators, community clinic leadership, individual citizenship activity occupy much time and effort. Extension of these activities on the part of many other physicians would be gratefully noted by all interested in mental health and would contribute to the common good.

The Mental Health Committee of the Women's Auxiliary, with Mrs. Wendell F. Roller of Monmouth as chairman, has done a fine job of distributing helpful educational material this year. We trust the husbands of the "Auxiliarians" have read these informative presentations.

One last (?) word. We recognize the reorganization principle of committee set up by the Council and its Committee on Disease Control, of which we are a subgroup. Nevertheless, patients with mental illness occupy more beds than all other illnesses combined. All of these patients in Illinois at one time or another have come within the purview of physicians or clinics and have been seen by members of our society. We must not lose sight of them because they are in hospital. Nor can we as taxpayers afford not to do all in our power to work toward prevention, expedite diagnosis, and further adequate treatment for these individuals. Does or does not the attempt of this committee still fall in "subgroup" classification? That is for the House and the Council to decide.

Respectfully,

F. Garm Norbury, M.D.
Chairman
Walter Baer, M.D.
Richard J. Graff, M.D.
David M. Jordan, M.D.
Harry E. LaPlante, M.D.
John J. Madden, M.D.
Harry Nesmith, M.D.
Harry Phillips, M.D.
John L. Reichert, M.D.
Murray E. Rolens, M.D.

TUBERCULOSIS CONTROL

The Tuberculosis Control Committee of the Illinois State Medical Society has continued its cooperative advice to the Illinois Department of Public Health, the Illinois Tuberculosis Association, and The Tuberculosis Institute of Chicago and Cook County, as well as all of the sanitarium boards responsible for tuberculosis control and ultimate eradication of tuberculosis in the state. Tuberculosis remains the number one public health contagious disease problem in the state of Illinois.

During the year the committee worked with the Illinois Department of Public Health Hospital Division in the revision of hospital standards for tuberculosis care. Today, adequate medical staff, laboratory and surgical facilities are very important in this total control program. There are enough beds in the state of Illinois today to take care of all of the acute, contagious cases of tuberculosis.

The committee continues to concentrate its efforts on measures to find the disease as early as possible. In this regard, hospital admission

x-rays and surveys in the upper age group, especially in large population centers, hold the highest priority for the early recognition and effective treatment of this disease.

Respectfully submitted,
E. A. Piszczek, M.D.,
M.P.H.

Ethical Relations Committee

The Ethical Relations Committee wishes to report that it had no work to do in the past year.

Respectfully submitted,
Charles Allison, M.D.,
Chairman
V. B. Adams
R. C. Oldfield, M.D.

Committee on Industrial Health

An Indoctrination Dinner was held for the 146 panel members in 21 specialities at the Drake Hotel on June 4, 1959.

The Honorable John B. M. McNally of the Supreme Court of New York City, Preston A. Wade, M.D., and John B. Hannum III, a Philadelphia attorney, gave the assembled panel members all of the details from the viewpoints of a judge, doctor, and lawyer with reference to Impartial Medical Testimony.

The Honorable John B. M. McNally had spoken that morning to the 125 judges of the Judicial Conference of the State of Illinois at Northwestern University Law School.

On October 8 the Executive Committee on Impartial Medical Testimony met with the Judicial Conference, Seventh Circuit of the U. S. District Court. The Honorable William J. Campbell, Chief Judge, U. S. District Court, said, "I would like to say personally, and on behalf of this Court, and on behalf of the profession that we are privileged to represent, that we owe the Illinois State Medical Society a debt of gratitude, and we want to thank them for their services to us and to the cause of the fair administration of justice."

On November 2, Rule 20 of the Civil Rules of the U. S. District Court for the Northern District of Illinois was adopted. The Rule became effective Tuesday, November 3 and the first panel member was appointed on Friday, November 6, 1959.

On October 19 the Honorable Bernard Botein, Presiding Justice, Supreme Court of the State of New York, was the principle speaker at our second Indoctrination Dinner for panel members.

On November 24, the Council of the Illinois State Medical Society relieved the Committee on Industrial Health of all duties pertaining to Impartial Medical Testimony. A new Committee on Impartial Medical Testimony was appointed by the Council.

Since November 24, 1959 The Committee on Industrial Health has strictly adhered to matters pertaining to Industrial Health only.

R. J. Bennett, M. D., *Chairman*

The Fifty Year Club

THE FIFTY YEAR CLUB held its annual meeting the first day of the state meeting last May. One hundred and fifty of the present 491 members and their guests attended the complimentary luncheon. Many members came from other states to meet their old friends.

T. R. Van Dellen, M.D., medical editor of the Chicago Tribune, was our guest speaker. His address was interesting and enjoyed. Following his address, 12 members of the Chicago Medical Society were inducted into the Fifty Year Club.

Many of those present at the banquet in Monmouth honoring Dr. Harold M. Camp on September 24, 1959, only three weeks before his death, considered it one of the outstanding affairs of its kind since the organization of the club. Approximately 300 physicians and townspeople, including members from all parts of the state, filled the Monmouth College dining room to capacity to honor one who had taken a leading role in the organization of our Fifty Year Club.

Since the Fifty Year Club was organized in 1937, more than 1,400 physicians have been inducted into it.

The Secretary's office reports that 29 downstate members and 36 members of the Chicago Medical Society will become eligible for membership during the current year.

Our Fifty Year Club was the first of its kind organized in the United States. Since then several states have followed suit.

Committee Members
Andy Hall, M.D.
E. D. Davis, M.D.
B. Barker Beason, M.D.
William S. Bougher, M.D.

Impartial Medical Testimony

This is a progress report. The council of the Illinois State Medical Society is familiar with the organizational work of this committee. In the past year the U. S. Federal Court of Northern Illinois adopted Rule 20 and has put into effect the Panel of Medical Experts, whose names are in the possession of the Executive Secretary of the Illinois State Medical Society. During the past few months representative members of your committee met with the Northern Illinois U. S. Federal Judges to advise and assist in the organizational framework of the newly adopted program.

The objective of the Committee on Impartial Medical Testimony is the presentation of the medical truth. In other jurisdictions where this program is in effect—it was started in New York City—the impetus for impartial medical testimony came from the judges. When evidence is presented in court as to nature and extent of injuries, and there is diversity of opinion between the doctors for the plaintiff and defense, the court and jury are in a quandary to establish the medical truth. Thus the Illinois State Medical Society is the first in the United States in which the program for Impartial Medical Testimony was started by the doctors. There are several states who have sent doctors and lawyers to discuss the problem of the impartial medical witness with members of your committee and are much impressed with the Illinois plan.

Plans are in progress to establish impartial medical testimony in the Superior and Circuit courts throughout the State of Illinois, and in the Federal Courts in southern Illinois. Several meetings were held with the panel members in the Chicago-Cook County area. The Secretary's office of the Illinois State Medical Society has distributed illustrative case histories and other important literature to all panel members.

The last meeting of the Committee on Impartial Medical Testimony was held on January 30, 1960, at the Sherman Hotel.

A motion (Roper-DuPuy) was accepted that specialty societies be asked for approval of the impartial medical testimony plan. Thus far resolutions approving this plan have been adopted by the American College of Surgeons, American Bar Association, American Association for the Surgery of Trauma, Chicago Ophthalmological Society, Chicago Roentgen Society, Chicago Pathological Society.

A motion (DuPuy-Condon) was carried that the Council of the Illinois State Medical Society ask each councillor outside of Cook County to prepare a list of screened panel members in his district.

The value of the plan of impartial medical testimony is emphasized in a report in an eastern jurisdiction over a six-year period. A total of 554 cases were examined and 391 cases or 72 per cent were settled short of final judgment and verdict (290 cases or 52 per cent before trial arrangement, and 101 cases or 20 per cent settled after trial arrangement). There were 62 cases or 11 per cent survived through verdict or judgment, and 101 cases or 17 per cent were remanded, transferred, withdrawn, dismissed or awaiting completion of examination. Here is a dynamic example of the impartial medical testimony plan in action and the meaning of medical truth. The courts by pretrial hearing can dispose of many cases and reduce the large backlog that exists.

The Illinois State Medical Society plan on impartial medical testimony has been in operation but a few months in the Northern Illinois U. S. Federal Court. The opinion of the physicians called as experts in the various specialties has been most favorable and encouraging. Your committee plans very shortly to receive an expression from the presiding judges on the function and operation of this program.

Your committee is most grateful to the Council and members of the Illinois State Medical Society for their support of the Committee on Impartial Medical Testimony in the continuation of the medical truth and justice.

Samuel A. Levinson, M.D., *Chairman*
Newton DuPuy, M.D.
Arthur F. Goodyear, M.D.
Percy E. Hopkins, M.D.
Richard J. Bennett, M.D.
Aaron Kanter, M.D.
LeRoy Sloan, M.D.
Norman Roberg, M.D.
Wright Adams, M.D.
Clinton Compere, M.D.
Roland Mackay, M.D.
Harold Voris, M.D.
Roger Harvey, M.D.
Kenneth Roper, M.D.

Vivian Siegel, M.D.
John Condon, M.D.
Warren Young, M.D.
Ex Officio:
Joseph T. O'Neill, M.D.
H. Close Hesseltine, M.D.
George C. Turner, M.D.
Theodore R. Van Dellen, M.D.

Liaison—Illinois Hospital Association
Insurance
Maternal Welfare
Medical Economics

Reports not received in time for publication

Narcotics Committee

Although no formal meetings of the Narcotics Committee have been held during the current year, close liaison has been continued with the State Division of Narcotics Control.

In compliance with the recommendation of the 1959 Reference Committee as approved by the House of Delegates, a page in each issue of the Illinois Medical Journal for a period of six months was devoted to questions and answers relating to the medical use of narcotics under the Illinois Narcotic Act. These articles were prepared by Mr. Malachi L. Harney, superintendent, and Mr. John C. Cross, assistant superintendent, of the Division of Narcotics Control, and detailed various phases of possible hypothetical problems which might be encountered by physicians. Although provision was made for physicians to write to the Narcotics Committee for answers to questions or solutions of any problems encountered, only one query was received in the six-month period.

This committee is appreciative of the cooperation and assistance shown by Mr. Harney and Mr. Cross during the past year.

Since the year 1960-61 will be a legislative year and possibly bring proposed amendments to the Narcotic Act, it is recommended that the Narcotic Committee be continued.

Respectfully submitted,
Jacob E. Reisch, M.D., *Chairman*
Earl H. Blair, M. D.
Eli L. Borkon, M. D.
K. Dexter Nelson, M. D.
George S. Schwerin, M. D.

Committee on Necrology

It seems fitting to open this report with official notice of the death of the one who prepared earlier ones for many years, Dr. Harold M. Camp, who passed away on October 17, 1959, at the age of 74. "Mr. Illinois State Medical Society," as he was introduced on many occasions, served this society as secretary for 35 years and had been editor of the Illinois Medical Journal since 1941. He served the society as councilor for two years before his election as secretary, and during World War II, as state chairman of the Procurement and Assignment Service for Physicians under the War Manpower Commission.

A year before his death he was honored by his alma mater "in recognition of worthy achievement which has reflected credit upon Northwestern University and her alumni." Only three weeks before his death he was honored by his county medical society at a special dinner, at which time he received his Fifty Year certificate from Dr. Andy Hall of Mt. Vernon. Members of the society came from all parts of the state to honor him on this occasion. Many members in attendance at the 1959 annual meeting will recall Dr. Camp's coming directly to the meeting from a Chicago hospital following surgery for the condition that was to result in his death.

Five weeks later Dr. Roland Cross, long-time friend of Dr. Camp, who had served 19 years as director of the Illinois Department of Public Health, under four governors, passed away on November 28. It was seldom that Doctor Cross missed a meeting of the Council of this society. Under his capable leadership, relations between the state department and this society were ideal. Dr. Cross will be greatly missed by our membership.

Deaths of the following members of the society also have been reported to the secretary's office since our last annual report:

Adams, Walter A., Chicago, died March 7, 1959. Chief of the psychiatry department at Provident hospital.
Banfield, Samuel R., Highland Park, died April 25, 1959.
Barbour, Fredric L., Chicago, died February 7, 1959.
Barker, Reuben A., Alton, died August 6, 1958.
Barr, Herman P., Chicago, died August 22, 1959.
Becker, Israel, Chicago, died March 10, 1959.
Beebe, Leslie W., Oak Park, died June 19, 1959.
Bibb, Charles W., Chicago, died October 12, 1959. First Negro physician elected to office in Chicago Medical Society.
Blickenstaff, Augustus J., Peoria, died February 11, 1959.

Bohringer, George A., Chicago, died November 9, 1959.
Bonin, Hans, Sarasota, Fla., died May 11, 1959.
Bower, Lester E., Chicago, died March 3, 1959.
Braude, Morris, Chicago, died June 18, 1959.
Broman, Martin R., Evanston, died August 16, 1959. Director of laboratories at Swedish Covenant Hospital.
Brown, Louis S., Hillsboro, died August 27, 1959.
Buczynski, Charles C., Chicago, died May 22, 1959.
Burbach, William M., Chicago, died July 18, 1959.
Burton, Edgar C., Genoa, died October 16, 1959.
Butterman, Albert, Chicago, died November 16, 1959.
Candela, Rolando D., Chicago, died November 8, 1959.
Cantwell, Thomas O., Harvey, died July 9, 1959.
Clark, Dwight E., Chicago, died July 24, 1959. Chairman of department of surgery at University of Chicago.
Cohan, George L., Washington, died July 8, 1959.
Colwell, John B., Champaign, died September 17, 1959. Founder of Colwell Publishing Company, publishers of appointment books.
Compton, Charles W., Springfield, died July 6, 1959.
Cubbins, William R., Chicago, died November 15, 1959. Member of faculty of Northwestern University Medical School for 34 years; chief of surgical staff of Cook County Hospital for 12 years.
Culbertson, Ora J., East St. Louis, died May 29, 1959.
Culver, Harry, Chicago, died August 5, 1959. Formerly chief of department of urology at Cook County Hospital. Member of Editorial Board of Illinois Medical Journal for many years.
Davies, William, Lyons, died April 19, 1959.
Davis, Clara M., Winnetka, died April 8, 1959.
DeMotte, Roy J., died February 16, 1959.
Denney, Elliott S., Aurora, died December 23, 1959.
Dewein, Edward G., Freeburg, died June 29, 1959.
DeYoung, George M., Peoria, died January 27, 1960.
Diggs, N. Alfred, Chicago, died June 25, 1959.
Dolan, Martin A., Chicago, died February 19, 1959.
Dorne, Philip H., Chicago, died August 20, 1959.
Douglas, Edmund T., Hillsboro, died February 9, 1959.
Drennen, Clyde L., Polo, died December 18, 1959.
Driskell, Cecil R., Springfield, died May 20, 1959.
Farmer, David K., Mansfield, died December 15, 1958.
Fash, James C., Galesburg. died May 12, 1959.
Felsher, Wolf Zachary, Chicago, died May 11, 1959.
Fischer, Andrew L., Hoffman, died September 28, 1959.
Fischer, Edward F., Alton, died September 22, 1959.
Fisher, Nelson F., Chicago, died April 25, 1959.
Formusa, Anthony C., Melrose Park, died September 29, 1959.
Frazier, Frederick G., Chicago, died August 26, 1959.
Freeman, Alexander S., Chicago, died June 22, 1959.
Gethner, Max P., Chicago, died March 4, 1959.
Gooder, William V., Marengo, died August 10, 1959.
Goodwin, Perry B., Peoria, died January 1, 1960.
Gormley, John H., Evanston, died March 14, 1959.
Gottstein, Warner K., Chicago, died November 22, 1959.
Grant, Richard S., Chicago, died December 31, 1959.
Gregg, Arthur W., Chicago, died August 26, 1959.
Greer, Charles E., Charleston, died June 1, 1959.
Grimm, Emery G., Chicago, died March 19, 1959.
Harris, Richard A., Quincy, died October 6, 1959.
Harrison, Bruce A., Colchester, died February 3, 1960.
Hart, John T., Chicago, died April 30, 1959.
Heiss, Harry, Chicago, died June 29, 1959.
Hift, Robert, Chicago, died December 22, 1958.
Hubbell, Joseph A., Chicago, died April 29, 1959.
James, Jasper M., Henning, died November 29, 1959.
James, William A., Oak Park, died March 3, 1959.
Johnston, Louis C., Chicago, died June 1, 1959.
Kanter, Joseph, Chicago, died September 18, 1959.
Kionka, Paul B., Melrose Park, died November 9, 1959.
Kabaker, Charles B., Chicago, died October 7, 1959.
Kelly, Paul E., Chicago, died March 28, 1959.
Klapman, Jacob W., Chicago, died May 4, 1959.
Kohlenbach, Stephen, Columbia, died March 13, 1958.
Koll, Irvin S., Beverly Hills, Cal., died April 10, 1959.
Kosse, James, Chicago, died April 10, 1959.
Lalor, Joseph C., St. Petersburg, Fla., died December 23, 1959.
Landes, Herbert E., Chicago, died September 24, 1959. Chairman of department of urology at Stritch School of Medicine.
Lane, Myrven A., Chicago, died June 25, 1959.
Lang, John M., Del Mar, Cal., died October 6, 1959.
Latta, Philip R., LaGrange, died July 17, 1959.
Lipnik, Benjamin, Momence, died July 30, 1959.
Lippman, Louis S., Chicago, died September 1, 1959.
McGrath, Harold F., Chicago, died October 13, 1959.
McIntosh, Jesse H., Arcadia, Mo., died November 14, 1959.
Mackowiak, Felix A., Chicago, died March 5, 1959.
Magill, Samuel R., Springfield, died April 4, 1959.
Major, Ralph J., Momence, died November 19, 1959.
Marshall, William R., Clinton, died December 11, 1959. Served as secretary of the DeWitt County Medical Society for 26 years.
Mart, John A., Chicago, died September 12, 1959. Served as director of exhibits for annual meeting for several years.
Martin, Clement L., Chicago, died August 15, 1959.
Maryan, Harry O., Chicago, died March 28, 1959.
Mautz, George J., Springfield, died January 23, 1960.
Monaco, Attilio, Elmhurst, died September 20, 1959.
Metzger, Herman, Chicago, died March 12, 1959.
Miller, Clay O., River Forest, died May 24, 1959.
Morrison, Winfield S., Minonk, died August 17, 1959. Served as secretary of the Woodford County Medical Society for 15 years.
Munoz, Roque, N. A., Chicago, died September 9, 1958.
Needham, Frank S., Oak Park, died September 22, 1959.
Norris, Millard F., Springfield, died February 13, 1960.
Nystrom, Elmer E., Peoria, died February 23, 1959.
Otradovoc, Joseph H. M., Chicago, died November 6, 1959.
Orcutt, Dwight C., Evanston, died May 13, 1959.
Proxmire, Theodore S., Lake Forest, died December 16, 1959. Past president of the Lake County Medical Society.
Parmacek, Louis, Elgin, died November 2, 1959.
Rabenneck, Paul B., Nashville, died April 9, 1959. Served as president of Washington County Medical Society for many years. President of Southern Illinois Medical Association at time of death.
Rhodes, Walter R., Toledo, died November 29, 1959. Past president of Coles-Cumberland County Medical Society.
Robertson, Sylvan H., Highland Park, died December 6, 1959.
Rosenstiel, Mary L., Freeport, died May 17, 1959.
Roth, Charles R., Chicago, died June 8, 1959.
Ross, Paul E., Utica, died April 13, 1959.
Sandberg, Ivan M., Lostant, died June 26, 1959.
Sayre, Bernard, Chicago, died March 30, 1959.
Schnaer, Ira L., Evanston, died October 16, 1959.
Schrader, Edwin F., Macomb, died July 2, 1959.
Seguin, A. C., Des Plaines, died February 11, 1960.
Sharrer, Gerald L., Aurora, died July 23, 1959.
Simkus, Vincent A., Chicago, died September 12, 1959.
Sinclair, Jordon F., Chicago, died October 20, 1959.
Somers, Charles J., Lansing, died June 24, 1959.
Staff, Edmond P., Ramsey, died April 18, 1959.
Stephenson, Albert O., Chicago, died March 28, 1959.
Sternes, Frank C., Chicago, died June 26, 1959.
Stiers, Fred L., East Peoria, died December 23, 1959.
Sullivan, Ralph C., Oak Park, died April 29, 1959.

Taylor, Ruth E., Chicago, died July 18, 1959.
Teller, Ernest, Chicago, died April 11, 1959.
Thieda, Arthur A., Cicero, died October 21, 1959.
Thompson, George F., Chicago, died November 9, 1959. Past president of the Chicago Surgical Society.
Thorek, Max, Chicago, died January 25, 1960. Founder of the International College of Surgeons.
Toth, John J., Chebanse, died December 7, 1959.
Troupa, Alburt B., Princeton, died April 1, 1959.
Turner, Vernon C., Evanston, died November 21, 1959. Chairman of department of orthopedics, Evanston Hospital.
Twohey, Joseph T., Chicago, died December 27, 1958.
Vander Veer, Adrian H., Chicago, died August 13, 1959.
Van De Sand, Gerard, Fulton, died November 5, 1958.
Van Wormer, Frank B., Mechanicsburg, died February 17, 1960.
Verneuil, Julius L., Collinsville, died October 25, 1959.
Vetter, James H., Rockford, died September 3, 1959.
Walsh, John Joseph, Chicago, died July 29, 1959.
Waters, Gregory R., Hinsdale, died June 25, 1959.
Wead, John T., Wyoming, died December 22, 1959.
Webb, Byford H., West Frankfort, died January 21, 1959.
West, Arthur D., Moline, died December 7, 1959.
Weigen, Anders J., Lincolnwood, died September 27, 1959. Trustee of the Chicago Medical Society. Formerly served as a section officer for the Illinois State Medical Society.
Wheeler, David R., Evanston, died July 7, 1958.
Whitmer, Ralph G., Des Moines, Iowa, died November 12, 1959.
Wood, George C., Effingham, died June 25, 1959. Past president and secretary of the Effingham County Medical Society.
Wright, Oren H., Chicago, died December 30, 1958.
Wynn, Joseph H., Naperville, died May 11, 1959.
Young, Walter H., Maywood, died October 14, 1959.
Zaletel, Rudolph P., Lincoln, died May 10, 1959.
Zessin, E. T. P., Galesburg, died July 27, 1959.

There are doubtless many additional deaths in the membership of this society, some of which will not be reported for months. Unfortunately county society secretaries and members of physicians' families are slow in reporting deaths of members.

Although a Committee on Necrology was authorized by the House of Delegates at the 1952 annual meeting and a committee was appointed for several years thereafter, it eventually became apparent that a committee was not in a position to record the deaths, and that it was the responsibility of the secretary's office. The writer, whom Dr. Camp enjoyed facetiously referring to as the "Necrologist," has compiled this list and apologizes for errors and omissions.

Respectfully submitted,
Jane Z. Swanson
Secretary's Office

CONSTITUTION AND BY-LAWS

The Committee on Constitution and By-Laws has had a busy year. The Report of Survey by Rogers, Slade & Hill was completed about May, 1959. The survey was made while the 1958 revision of By-Laws was effective, and it recommended certain changes in both the Constitution and By-Laws. About the same time that the report of survey arrived, the House of Delegates (May, 1959) was making certain changes in the Constitution and By-Laws, some of which were the ones being recommended by the survey.

Therefore, your committee has been and still is faced with directives: (1) to implement certain changes, some of which have already been revised by the House in May, 1959; (2) by contradictory instructions from the May and December meetings.

The report of the December, 1959, meeting indicates that action by the House on the recommendations of the Rogers, Slade & Hill survey are final. The proposed changes in the Constitution and By-Laws to implement these changes cannot be final until the annual meeting in May, 1960, because of the provision that changes in the Constitution and By-Laws can be made only at the annual meetings.

The Committee on Constitution and By-Laws will have a supplementary report for the May meeting, which will contain all of the changes asked for by House at the December, 1959, meeting.

W. C. Bornemeier, *Chairman*
Andres Brislen
Fred Endres
Arthur Goodyear
Ralph Redmond

Committee on Nursing

There has not been any appreciable change in the status of the number of training schools, graduate nurses, or student nurses since last report.

Your committee met with the Committee on Nursing of the Illinois Hospital Association on Nov. 15, 1959, at the Sherman Hotel in Chicago for the purpose of discussing problems of mutual concern and interest in regarding the current nursing situation, and to define the areas where the two groups could cooperate in the search for solutions of the mutually recognized problems.

Major problems discussed were:

1. Shortage of number of nurses graduating from present schools to fill present positions.
2. Shortage becoming more acute because of constant increase in number of hospital beds.
3. Shortage of graduate and student nurses enrolled in degree programs.
4. Lack of interest in opening new educational programs, and definite need to develop and provide educational programs in hospitals with adequate training facilities.
5. Problem of educating and producing sufficient qualified L.P.N.'s.

After considerable discussion it was determined to invite the Illinois League for Nursing, Illinois Nurses Association, and Department of Registration and Education to meet with the combined committees of the Illinois Hospital Association and Illinois State Medical Society in an endeavor to explore all possible avenues of cooperation toward finding solutions to the problems in Illinois. A subcommittee consisting of three members from each organization was appointed to gather materials and facts to be sent to each committee member so that he would be well informed.

A meeting of the subcommittee was held on Dec. 12, 1959, at the LaSalle Hotel, after considerable discussion it was determined that enough facts were not available at this time to have a joint meeting as had been previously planned.

A supplementary report will be made at the time of the regular meeting.

William H. Schowengerdt, M.D., *Chairman,* Champaign
Maurice M. Hoeltgen, M.D., Chicago
J. O. Firth, M.D., Monmouth
Paul P. Youngberg, M.D., Moline
F. M. Nicholson, M.D., Chicago
Patrict H. McNulty, M.D., Chicago
Willard Scrivner, M.D., E. St. Louis
Raleigh C. Oldfield, M.D., Oak Park
Mary Louise Newman, M.D., Jacksonville
Newton DuPuy, M.D., Quincy

Committee on Nutrition

Committee on Polio Control

Reports not received in time for publication

Postgraduate Medical Education and Scientific Service

County medical societies in the last year were asked repeatedly to set up postgraduate conferences for the benefit of their members. Some of the best teachers in the state are available for that purpose.

Nevertheless, the Committee on Postgraduate Medical Education and Scientific Service was called upon to arrange fewer conferences than the year before. This is a great disappointment because physicians throughout the state missed the opportunity to gain valuable knowledge of new developments in diagnosis and therapy.

Another program was presented at Springfield March 3 (District 5). Despite heavy snows and extremely cold weather, there was an attendance of 65 physicians, well pleased by the manner in which teachers from the University of Illinois College of Medicine covered the subjects.

Another conference was scheduled for Mattoon (District 8) April 7. This program was presented by Mercy Hospital staff.

This report is being prepared prior to the last conference of the fiscal year which will be presented April 28 at LaSalle (District 2) by members of the faculty of Chicago Medical School. the opportunity to gain valuable knowledge of new developments in diagnosis and therapy.

The committee is prepared to serve county societies by providing outstanding programs. However, the requests for conferences must come from county levels.

The first meeting of the current year was held at Champaign (District 8). The program was presented by a team from the Stritch School of Medicine Loyola University. There was an attendance of 83 physicians. Reports of those present were heart warming.

SCIENTIFIC SERVICE

Programs arranged April 1, 1959 to March 31, 1960—99.

County medical society programs—57 serving 21 counties:

Bureau, DeKalb, DuPage, Effingham, Greene, Henry, Kankakee, Knox, LaSalle, Logan, Macoupin and Montgomery, McDonough, Morgan, Southern Illinois Medical Association, Stephenson, Vermilion, Whiteside and Lee, Englewood and Stockyards Branches of the Chicago Medical Society.

Lay group programs—27

Radio programs—15

Double postcard notices mailed: 4,206

Single postcards mailed: 443

News Releases: 844

LIST OF SPEAKERS' BOOKLETS

Since the release of our "List of Speakers Booklet" in February, 1958, approximately 100 additional names of physicians willing to participate in county medical society programs have been received. These names have been mimeographed by category on loose leaf sheets and sent to program chairmen.

SPEAKERS' BUREAU ACTIVITIES

Programs have been arranged for lay groups: 27. These included parent-teacher associations, women's clubs, woman's auxiliary to the North Shore Branch of the Chicago Medical Society, Fifth U. S. Army Personnel Officers, Divorcees Anonymous, Pre-Medical Club of the University of Chicago, elementary and high schools for Youth Week, Golden Age Clubs, Skokie Chapter City of Hope, Pearl Franklin Hadassah, and the Licensed Practical Nurses' Association. The subjects requested covered Factors in Keeping Healthy, The Role of the Physician in Society, Psychosomatic Illnesses, Dynamic Psychiatry, Health of the Executive, High Blood Pressure, Medical Careers, Care of the Eyes of School Children, and various topics pertaining to child health and welfare.

Although the publication HEALTH TALK was discontinued nearly three years ago, some 30 or more requests for it have been received. "Blue Print for Health", the Blue Cross Health Digest, continues to feature certain issues.

RADIO

"Your Health Comes First" over Radio Chicago WJJD: Radio Talks given: 15 — most of them in question and answer format with the physician and announcer participating. This series of fifteen-minute recorded radio programs was initiated on February 25, 1959, as a public service presentation sponsored by our state society in cooperation with Radio Chicago WJJD. Since that time, a program has been presented on the fourth Wednesday evening of each month, with the exception of December. It is aired on the last fifteen-minute segment of the station's broadcast day, so that the hour varies from about 6:00 p.m to 9:45 p.m.

In December, four ten-minute talks titled "Helpful Health Hints" were presented. The subjects covered were Suggestions for Happy Holidays, A Positive Health Program for Older Persons, What To Do in a Medical Emergency, and Your Health in Winter.

During the period of this report, the following physicians participated: Doctors R. Charles Oldfield, Jr., Edwin F. Hirsch, Paul K. Weichselbaum (deceased), Edward A. Piszczek, Robert E. Lee, Coye C. Mason, Donald H. Atlas, Paul K. Anthony, Robert R. Mustell, George Gee Jackson, Donald I. Bell, and William A Larmon.

MISCELLANY

A series of six psychiatric programs were arranged for Logan County Medical Society at the request of the president, Dr. Albert R. Siegel. We have learned from several sources that they have been very well received by the physicians of the area.

Request was received for a physician to address a special meeting of physicians and morticians. A pathologist was secured who discussed "Value of the Autopsy."

A presentation on "arthritis" was arranged for the 85th annual meeting of the Southern Illinois Medical Association in Harrisburg, November 5.

Your chairman has been embarrassed on several occasions by having to cancel engagements with physicians who had accepted speaking invitations. Program chairmen, in three or four instances, unwilling to wait until we had completed the appointments, had gone ahead and secured speakers direct.

On the other hand, some chairmen sent in their requests in the fall outlining suggestions for speakers and subjects for their entire season. One such was the program chairman of the Stock Yards Branch of the Chicago Medical Society. We were able to complete a schedule of six programs by early October.

Programs have been completed for the next few months.

In conclusion, your chairman wishes to thank the many physicians who have cooperated so whole heartedly in the various educational activities of this committee.

Respectively submitted,

Louis R. Limarzi, M.D.,
Chairman
George E. Kirby, M.D.,
Co-Chairman
J. H. Maloney, M.D.
Julius M. Kowalski, M.D.
Gilbert D. Krause, M.D.
N. C. Barwasser, M.D.
Emmet F. Pearson, M.D.
Paul A. Dailey, M.D.
Max Hirschfelder, M.D.
William H. Schowengerdt, M.D.
Frank P. Skaggs, M.D.
William Mohlenbrock, M.D.
E. F. Neckermann, M.D.

Physically Handicapped Children

While the number of crippled children's clinics are quite adequate to properly evaluate and care for the crippled child, the character of the deformities and abnormalities are still on occasion problematical. Formerly more diseases and neglect and longer periods of home care preceded visits to the crippled children's clinics. Patients had tuberculosis, neglected poliomyelitis, congenital deformities, luetic conditions, and others. The trend today is for parents to bring their children to their family physician promptly; he in turn refers them to specialists.

In 1960 there are far more qualified orthopedic surgeons than ever before. Great advances have been made, not only in the care of handicapped children, but in the prevention of crippling conditions. The general practictioner, especially when trained here in America, possesses the necessary acumen to make an early diagnosis and to place the patient in the hands of the orthopedic surgeon without delay. Many of these con-

RESUME OF HANDICAPPED CHILDREN SEEN AT CLINICS

Institution and Type of Clinic	Total Attendance	No. of Clinics	Av. per Clinic	Remarks
Univ. of Ill. Div. of Services for Crippled Children				
General orthopedic	9,867	198	49.83	
Cardiac	834	29	28.76	
Cerebral palsy	298	21	14.19	
Mandel Clinic at Michael Reese				
Child. orthopedic		97	11.10	
Cerebral palsy		48	9.40	
Univ. of Chicago Child. orthopedic				Handicapped children seen at random. No specific data.
Children's Memorial	1,182	100	12.00	
Shriner's Hosp. for Crippled Children		102	40.00	
Central Free Dispensary				6,426 pediatric visits (not broken down)
Ill. Elks Assn. for Crippled Children	2,061	59	34.93	
Montgomery Ward at N.U. Med. School				5 clinics weekly with av. of 2 children per clinic
Cook County				
Orthopedic clinic			11.04	4 days weekly
Mentally retarded			8.53	2 days weekly
Cleft palate			8.50	1 day monthly
Ped. neurology			20.73	2 days weekly
Ped. cardiac			30.70	2 days weekly
Mt. Sinai Hosp.	Adult and children clinic twice weekly with av. of 2 or 3 children at each clinic. Pediatric-cardiac weekly — 5 or 7 per clinic and one for handicapped children — 68 per clinic.			

ditions, when taken at the onset, *i.e.*, absence of some members, congenital dislocation of the hip, metatarsus varus, and many others, have the advantage of guided growth.

Fortuitously, now more prevalent than ever before, is one of the major divisions in the resident training of the orthopedic surgeon. At a recent meeting of the Academy of Orthopedic Surgeons, the attendance was the highest of all times. The number of young orthopedic surgeons who took board examinations and passed was an all time high.

While the orthopedic profession has made great strides in the past, the members are well aware that the future is in no way predictable, and probably holds many knotty problems for which they must always be prepared.

Frank G. Murphy, M.D., *Chairman*

Committee on Radiation

No items have been referred to the committee for consideration. We are aware of the suggestions made at the House of Delegates meeting of the American Medical Society in Dallas regarding development of radiation survey matters among the profession.

Respectfully submitted,

Roger A. Harvey, M.D.,
Chairman

Rural Health and Student Loan Fund

A review of the statistics of our Illinois State Health Department would lead one to the conclusion that rural health in Illinois has probably never been any better than it is today. Our people's environmental sanitation is generally good. Obviously there are spots where sanitation and water pollution are still not 100 per cent satisfactory, but still they are greatly improved over 20 years ago.

The acceptance by our rural people of prepayment of hospital and medical care has been most satisfactory. Since the number of people on the land is decreasing each decade, it is not surprising that the enrollment in the Blue Cross Plan for rural people changes very little in our state. This would indicate that those who are left on the land are intelligently using their finances in the health field.

The problems of recruiting young men for a career in medicine are becoming more acute yearly. For each year during the last five years there has been a decreasing number of brilliant students taking up medicine. As we see it, this can be changed only by personal effort on the part of physicians in practice going out and recruiting the bright young people in their area.

The training of physicians in our state is extremely good. The retention of those physicians in Illinois is decreasing yearly. The most recent survey indicates that 60 per cent of the native-born of Illinois who are educated in Illinois go elsewhere as soon as they finish their training programs. There are no pat answers to this problem but two or three points of view expressed by the committee last year still obtain. First, the residency requirement must be tightened; otherwise we will continue to educate truly non-Illinoisans in our state medical school. Second, our state medical school could increase the number of trained physicians by going on a quarterly basis. Third, the profession must take more interest in recruiting folks from home and providing a place for them, at the end of their education, at home. Otherwise, our loss to other states will increase even more than it has.

The Student Loan Fund Board met this year and recommended, as usual, 10 young men for admission to medical school. Our finances were such that only five young men could be lent money to complete their medical education. The Loan Fund Board feels that the physicians in Illinois can not afford to put more than $100,000 in a revolving Loan Fund Program. It will be another year or two before this loan fund will revolve in a satisfactory manner to provide loans for four or five students per year. The Loan Fund Board feels that it is inadvisable for our two organizations to invest any more money than this in a revolving loan fund for personal medical education. The Loan Fund Board appears to be plagued with the problem of pepole who sign contracts and never abide by them. So long as we are dealing with people, it will be a problem.

We would continue to advise the House of Delegates and the state society's Council to put no more funds in the Loan Fund Program than necessary to make it self-sustaining and revolving as of now.

Respectfully submitted,

Harlan English, M.D.,
Chairman
E. S. Hamilton, M. D.
Jack Gibbs, M.D.

National Rural Health Conference

Several important aspects of rural health were reviewed at the National Conference on Rural Health, February 25-27, in Grand Rapids, Michigan.

A panel on medical careers, the opening day, brought out the fact that there had been a serious decline in applicants to enter medicine and its allied fields. In contrast to 1947 when the ratio of applicants to admissions to medical school was 11 to 1, that ratio has now declined to 1.7 to 1. The increasing shortage of physicians available for rural practice further complicates this problem.

Several suggestions for alleviating the problem were presented; among them were the following:

Farm groups and other groups represented were urged to encourage young people in the farm areas to enter medical fields by pointing out the opportunties for service of this kind in their own communities.

The communities could help by providing facilities to attract physicians and by setting up financial plans to provide assistance for medical and nursing education.

It was suggested that medical schools might be more aware of the need for rural physicians, and that curriculum changes and the formation of preceptorships should be considered with this in mind.

The panel on aging reviewed progress made in this field in the various states. It was felt that we should not consider those over 65 as a group, since there is such a remarkable variation in the health needs, work capacities, and economic status of individuals within the group. It was felt that labor and industry should review their present positions on compulsory retirement ages in the light of individual capacities, and that worthwhile activity is a deterrent to many of the problems of the aged. It was the unanimous opinion that legislation providing blanket health coverage for the people over 65 was unwise, and at this time need for such had not been established, in light of the number at present covered by voluntary health insurance plans. It was recommended that a team approach at the community level, could best solve local problems of the aged.

A panel on foods and nutrition pointed out that the present day trend of addition of vitamins to foods was being carried to extreme, and it was felt that this should be subject to closer scrutiny.

The routine administration of drugs and antibiotics in the feed of animals was severely criticized. It was felt that this probably decreases the life span in some cases and that it protects the genetically weak in others. It was also pointed out that it may affect normal immunological responses and produce resistant strains of bacteria. The continual exposure of humans to antibiotics in milk and meat may have far reaching consequences.

This was to be the last national conference on rural health. It was felt that it would be more effective to have regional conferences with the thought that they would be better attended, and more attention could be paid to regional problems. It was suggested that the conferences on rural health might be more effective if the people in the field of medical education could be encouraged to participate.

It was also suggested that rural health committees be formed at the county level with members of farm organizations participating.

I feel that pertinent problems were presented at the conference and that their solutions merit the concern of the entire medical profession.

It was my impression that if we are to continue to enjoy the support of the rural people against such federal legislation as the Forand Bill, tangible efforts on the part of medicine to improve rural health care, such as our own Student Loan Fund Plan, should be encouraged.

J. L. Gibbs, M.D.
Committee on Rural Health

Committee on School Health

The Committee on School Health met twice last year. At the first meeting October 10, we made two recommendations which were to be introduced to the Joint Committee on School Health:

1. Request the Joint Committee to appoint a committee to publicize the dangers of contact sports, such as football and boxing, in elementary school children as outlined by the Illinois Chapter of the Academy of Pediatricians.
2. Request the Joint Committee to appoint a committee to study and advise on health and accident policies for use in schools.

This was done and was favorably received by

the Joint Committee as a whole, but the executive committee had some objections and it was deemed better to postpone these recommendations until a more favorable time.

The second meeting was January 30. We considered the re-introduction of the two recommendations of the first meeting after the report of the 1960 White House Conference on Youth and Children was available.

There are some factors that should be emphasized in School Health. Twenty two percent of the population of Illinois is in school. This is an excellent avenue for future public relations activities by the medical profession. The greatest bottleneck in school health is lack of physician participation.

Respectfully submitted,

Willard W. Fullerton, M.D.,
Chairman
John Lester Reichert, M.D.
Arthur L. Shafton, M.D.
Ralph H. Kunstadter, M.D.
Homer C. Parkhill, M.D.
Kenneth S. Nolan, M.D.

Committee on Traffic Safety

The Council of the Illinois State Medical Society approved the Illinois-Cornell Automotive Crash Injury Research Project July 26, 1959. Doctor T. R. Van Dellen was then chairman of the society's Traffic Safety Committee. No further word was heard from the Cornell group until February, 1960, when a letter was received outlining their plans for a detailed study in a research project covering several counties in Illinois. The committee approved this by correspondence and requested the secretary's office to send the material to all physicians in the 12 counties in the North Central section of the state. The committee further requested that reference to the study be included in the letter from the secretary's office. This was done so that all county societies and branches might know of the project.

The committee feels that, in addition to physicians in the special-study area, all physicians in the state should be interested in this program and their cooperation should be sought in future similar studies. Other suggestions of the committee include (1) police in uniform and with marked cars at all times for the moral effect of their presence; (2) a general acceleration of traffic control enforcement rather than employment in checking parking meters, etc.; and (3) special emphasis on presence of local or State Highway Police in accident-prone areas.

A luncheon meeting of the committee has been scheduled during the annual meeting of the state society. It is possible that a supplementary report may stem from that.

Respectfully,

F. Garm Norbury, M.D.,
Chairman
James J. Callahan, M.D.
James M. Furrie, M.D.
George P. Guibor, M. D.
Lawrence J. Lawson, Jr., M.D.
Frank W. Newell, M.D.
Clifford Sullivan, M.D.
Paul P. Youngberg, M.D.
Edward Zinschlag, M.D.

RESOLUTIONS

Kendall County Medical Society — No. 1

WHEREAS, one of the prime interests of the Illinois State Medical Society — under Article II of the Constitution and By-Laws is — "to study and improve the standards of medical care and to inform the public and medical profession concerning the *advantages of good medical care*". and

WHEREAS, Socialism encourages irresponsibility, and

WHEREAS, irresponsibility destroys initiative and self-discipline, and

WHEREAS, loss of initiative and self-discipline creates anxieties and tensions that produce disturbances in normal body functions and render one incapable of coping with his problems and occupation, and

WHEREAS, a good proportion of patients seen in office practice suffer from the direct influence of anxieties and tensions that require medical care, therefore

BE IT RESOLVED, that the mental and physical health and performance of people are directly affected by Socialism, and

BE IT FURTHER RESOLVED, that the Constitution and By-laws of the Illinois State Medical Society make it not only possible but mandatory that it oppose Socialism as it affects the

mental and physical health of people, and
BE IT FURTHER RESOLVED, that the Illinois State Medical Society and the American Medical Association inform the public and the profession of this menace to public health.

Kendall County Medical Society — No. 2

WHEREAS, Socialism is a form of government which transfers personal responsibility to the State, and
WHEREAS, the long term welfare of mankind depends upon freedom of decision and action as well as individual responsibility, and
WHEREAS, such a transfer of responsibility in any form deprives individuals of the enriching variations of decision and freedom of action, and
WHEREAS, these variations are vital to the individual's accomplishments and his contributions to mankind, and
WHEREAS, our government is pushing on toward a Socialistic State, therefore
BE IT RESOLVED, that the Kendall County Medical Society respectfully urges the Illinois State Medical Society and its delegates to the American Medical Association to deplore and condemn all legislative proposals for destroying freedom of action and decision and responsibility for one's self, and
BE IT FURTHER RESOLVED, that organized medicine once again identify itself with human progress and betterment by opposing socialistic legislation, be it in the field of medicine or otherwise.

Kendall County Medical Society — No. 3

WHEREAS, irresponsibility is a disease of mankind, and
WHEREAS, organized movements are prone to encourage irresponsibility among their members who are a minority group, by assuming the members' right of decision and action, by coercion and other forceful methods, and
WHEREAS, such pressures restrict the Constitutional rights and freedoms of the majority of our people who are capable of and interested in assuming their own responsibility as well as the welfare of those less endowed, and
WHEREAS, Socialism is a symptom of the disease "irresponsibility", therefore
BE IT RESOLVED, that Kendall County Medical Society will not favor any legislation that will restrict the Constitutional rights and freedoms of its members or the people its members serve, and
BE IT FURTHER RESOLVED, that the Kendall County Medical Society urges the Illinois State Medical Society with the assistance of its council, delegates and appropriate committees, study and implement an improved policy of action in behalf of its membership that will encourage responsibility of people — and protect and guarantee the Constitutional rights of decision and freedom of action of all people who are ready, willing and able to assume their own responsibility.

Kendall County Medical Society — No. 4

WHEREAS, the objections of those who are to be exploited in the Forand Bill would have only selfish interest, and
WHEREAS, the Forand Bill is only one of many proposals of Social legislation before our Congress,
BE IT RESOLVED, that the Kendall County Medical Society objects vigorously to the action of the Illinois State Medical Society in opposing only the Forand Bill as though it were the only Socialistic bill before our Congress, and
BE IT FURTHER RESOLVED, that the Illinois State Medical Society exert its lobbying influence against all forms of Socialistic legislation as we would ask others to oppose the Forand Bill.

Kendall County Medical Society — No. 5

WHEREAS, organized medicine has assumed that medical care of the aged, 65 years of age or over with limited income is a medical problem at least in part, and
WHEREAS, the committee on aging and other representatives of the Illinois State Medical Society seek to propose a fixed fee form of medical insurance program in the State of Illinois in conjunction with Blue Shield, and
WHEREAS, such a program is offered as an alternative to the Forand Bill legislation, and
WHEREAS, any fixed fee for services rendered would limit responsible and ethical practicing physicians of their Constitutional right of decision and encourage their irresponsibility in their

care of patients, and
WHEREAS, only an increased and sustained responsibility of physicians can insure the best in medical services for people, therefore
BE IT RESOLVED, that the Kendall County Medical Society opposes any fixed fee Medical Service Plan for people age 65 or over with limited income on the basis that it would be an equally socialistic alternative to a government sponsored program, and
BE IT FURTHER RESOLVED, that the physicians of Kendall County will continue to take care of the medical needs of the indigent for little or no charge for services rendered, and
BE IT FURTHER RESOLVED, that the physicians of Kendall County will continue to render ethical services to people age 65 or over with limited income at a fee commensurate with their ability to pay, and
BE IT FURTHER RESOLVED, that the Illinois State Medical Society make every effort to uphold the right and freedom of decision and action of the physicians in the State of Illinois not only for the physicians but for the people they serve.

Kendall County Medical Society — No. 6

WHEREAS, inflation and the rising cost of living has made it difficult for our aging citizens to adequately plan for themselves a satisfactory retirement income, and
WHEREAS, forced retirement at age 65 has become the byword and policy of our industry, and
WHEREAS, present Social Security benefits are inadequate to meet the current needs for our aging citizens, and
WHEREAS, Social Security benefits are not allowed if an aging citizen, capable of further employment, should he seek to augment his income beyond certain limits, therefore
BE IT RESOLVED, that organized medicine, as represented by the Illinois State Medical Society and the American Medical Association direct their policies of action, propaganda and political lobbying against all legislative proposals that are inflationary, and
BE IT FURTHER RESOLVED, that all available channels of public communication be used in such a program, and
BE IT FURTHER RESOLVED, that this program be financed by an increase in the annual dues to the American Medical Association.

Kendall County Medical Society — No. 7

WHEREAS, the American Medical Association membership consists of over two hundred thousand practicing physicians, and
WHEREAS, this membership comprises an essential structure in the Social Welfare and health of our nation as experts in these fields, and
WHEREAS, the structure of the Illinois State Medical Society and the American Medical Association makes the membership of these organizations politically impotent in dealing with the social problems of medicine, therefore
BE IT RESOLVED, that organized medicine is better qualified to decide the medical needs of the people of our country than any other agency, and
BE IT FURTHER RESOLVED, that organized medicine alter its structure or form a separate political action group to more effectively deal with the problems of a socializing political economy, and
BE IT FURTHER RESOLVED, that the Illinois State Medical Society and American Medical Association lend their prestige, support and administrative facilities to such separate political action groups of organized physicians.

Kendall County Medical Society — No. 8

WHEREAS, the committee on aging of the Illinois State Medical Society has proposed a plan for medical care of people 65 years of age or over with limited income, and
WHEREAS, this plan is on the basis of a FIXED FEE for medical care in conjunction with Blue Shield Insurance, and
WHEREAS, a poll of the physicians of the Illinois State Medical Society to sound out approval or disapproval of this plan has been found to be ambiguous, evasive and confusing, and
WHEREAS, the vital nature of such legislation should have as close to total participation by the membership of the Illinois State Medical Society as possible, therefore
BE IT RESOLVED, that the individual County Medical societies poll their own membership, and
BE IT FURTHER RESOLVED, that the poll

be mandatory on the part of each County Society and its individual members, and

BE IT FURTHER RESOLVED, that poll include the following simplified questions:

1. Would you subscribe to a fixed medical fee for services rendered patients age 65 or over with limited income of not over $3000 per year per couple and $2000 per individual with an estate of not over $20,000?

   YES NO

2. Do you feel that you would like to preserve your right of decision in rendering your fees for medical services, regardless of insurance coverage or patients' ability to pay?

   YES NO

Kendall County Medical Society — No. 9

WHEREAS, publicity of the evils and the derogatory elements of medicine are notably always present in the eyes of the public, and

WHEREAS, the virtues of ethical, humanitarian practices of dedicated physicians are inadequately brought before the public, and

WHEREAS, medicine is practiced at a higher level of ethics than most professions and is worthy of more laudable publicity at this time, therefore

BE IT RESOLVED, that the Illinois State Medical Society and the American Medical Association step up their program of laudable publicity for public consumption using all the available channels of communication to enhance the dignity and virtues of medicine.

Yes, elementary, Mr. Holmes

Logan Clendening was an avid reader of Sherlock Holmes and no less addicted than millions of others. Clendening's interest is testified by his account of the arrival of Sherlock Holmes in Heaven.

"Sherlock Holmes is dead. At the age of eighty he passed away quietly in his sleep. And at once he ascended to Heaven.

The arrival of few recent immigrants to the celestial streets has caused so much excitement. Only Napoleon's appearance in Hell is said to have equaled the great detective's appearance. In spite of the heavy fog which rolled in from the Jordan, Holmes was immediately bowled in a hansom to audience with the Divine Presence. After the customary exchange of amenities, Jehovah said:

'Mr. Holmes, we, too, have our problems. Adam and Eve are missing. Have been, 's a matter of fact, for nearly two aeons. They used to be quite an attraction to visitors and we would like to commission you to discover them.'

Holmes looked thoughtful for a moment.

'We fear that their appearance when last seen would furnish no clue,' continued Jehovah 'A man is bound to change in two aeons.'

Holmes held up his long, thin hand. 'Good old Watson,' he replied. 'Surely they must differ from the rest of the race . . . . Their children resembled them very closely, however.'

'A moment,' interrupted Holmes. 'With luck — could you make a pretty general announcement that a contest between an immovable body and irresistible force would be staged in that large field at the end of the street — Lord's, I presume it is?'

The announcement was made and soon the streets were filled with a slowly moving crowd. Holmes stood idly on the divine portico watching them.

Suddenly he darted out into the crowd and seized a patriarch and his whimpering old mate; he brought them to the Divine presence.

'It is,' asserted Deity. 'Adam, you have been giving us a great deal of anxiety. But, Mr. Holmes, tell me how you found them.'

'Elementary, my dear God,' said Sherlock Holmes, 'they have no navels.'" *C. Frederick Kittle, M.D. Arthur Conan Doyle. J. Kansas Med. Soc. Jan. 1960.*

International nutrition standards

The Recommended Dietary Allowances of the Food and Nutrition Board U. S. A. "are designed to maintain good nutrition in healthy persons in the United States under current conditions of living and to cover nearly all variations of requirements for nutrients in the population at large. They are meant to afford a margin of sufficiency above minimal requirements and are therefore planned to provide a buffer against the added needs of various stresses and to make possible other potential improvements of growth and function."

The intent of the Canadian standard is quite different and involves the concept that "The ingestion of more of a nutrient than serves a clear physiological purpose is undesirable in the face of world scarcity of food, and may even be harmful to the individual under certain circumstances. . . . The standard is intended to be used (1) as a scientific basis for planning food supplies for individuals or groups, except where clinical observations and tests have established particular food requirements; (2) to assess the amount of each nutrient provided by a diet in terms of probable physiological requirements; and (3) to indicate a 'nutritional floor' beneath which the maintenance of health in people can not be assumed." In regard to the degree of success achieved by the Canadian Council on Nutrition in descending to the "nutritional floor" for vitamin A, thiamine, iron (adult males) and ascorbic acid, the reader may care to refer to the chapters in this book where these nutrients are discussed in detail.

Again, the Japanese standard has still a different objective as indicated in the following quotations from a 1958 report of the Ministry of Health and Welfare on Nutrition in Japan. "As a whole, . . . nutrition of the nation is still more to be improved. It is not enough to meet all the requirements, as the standard is based on the physiques of the Japanese of today, and we are satisfied to be the present physiques, which are, compared to many other nations, rather dwarfish. . . . We are not [really] satisfied, however, with just the recovery to the prewar state but aim to become one of the healthy, able-bodied and able-minded peoples of the world, and in a well-grown size, too." *Michael G. Wohl, M.D., and Robert S. Goodhart, M.D. Modern Nutrition in Health and Disease. Philadelphia, Lea and Febiger, 1960.*

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VARIDASE is not an anti-infective, but by increasing the permeability of the fibrin wall, it eases penetration of natural regenerative factors and fosters healthy tissue growth, making infection less likely.

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BOOK REVIEWS



A Practical Guide to General Surgical Management. Julian A. Sterling, M.D. $3. Pp. 67. New York, Vantage Press, 1959.

This small volume was prepared as a guide for hospital interns, residents, and others associated with the care of the surgical ward patient. The book is presented in outline form and is divided into four sections: General Policy and Report, General Procedure, Basic Care in Specific Operations, and Miscellany. Problems related to sub-speciality types of surgery are omitted.

Admittedly, the material included in this volume is that found most helpful to the group working at the Albert Einstein Medical Center in Philadelphia. It, therefore, contains references to procedures or specific therapeutic measures most effective at that institution. Discrepancies, minor in nature, include frequent interchange of metric and apothecary systems, frequent referral of problems to "consultants" rather than a "Practical Guide" for such, routine use of saline solution in the early postoperative period, the infrequency of follow-up care in the postoperative patient.

This volume, beyond its specific usefulness to the hospital and institution for which it was prepared, may serve also as an outline for preparing similar volumes for other institutions.

W. Harrison Mehn, M.D.

Pediatric Pathology. Daniel Stowens, M.D. $20. Pp. 676. Baltimore, William's & Wilkin's Company, 1959.

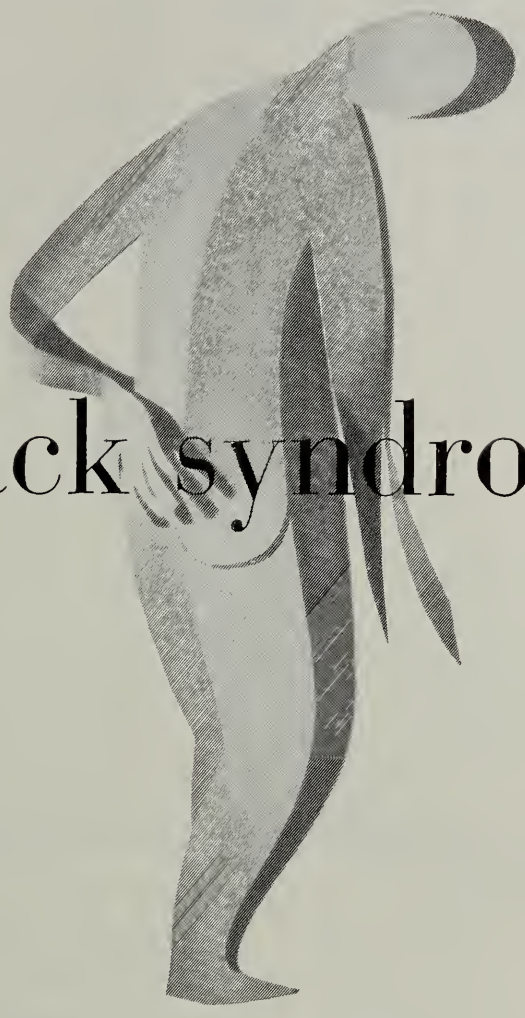
To write a text on the subject of pediatric pathology is a major task. Dr. Stowens has so organized the material that chapters consider disease so that similar etiologic agents are reviewed under one heading, e.g., Diseases Caused by Bacteria, Diseases Related to Hypersensitivity, Diseases Caused by Spirochetes. He has emphasized well the sections on growth and development and diseases of the newborn. In the attempt to make a comprehensive review of the pathology of childhood disease, many subjects have been of necessity covered in less detail than the reader often desires. Accordingly, this text would be of more value to the practicing pediatrician than to the physician desiring greater depth of approach to the pathology of specific conditions. Although there has been some attempt at correlating metabolic derangement with morbid anatomy, more of this will prabably be forthcoming in future editions. At the end of each chapter has been included fairly comprehensive bibliography of important papers on the subject.

Joseph D. Boggs, M.D.

The Microcirculation. Symposium on Factors Influencing Exchange of Substances

(*Continued on page* 64)

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relieves both stiffness and pain with safety... sustained effect

NOTABLE SAFETY—unusually low toxicity; no known contraindications: side effects are rare; drowsiness may occur, usually at higher dosage.

RAPID ACTION—starts to act quickly.

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BOOK REVIEWS (Continued)

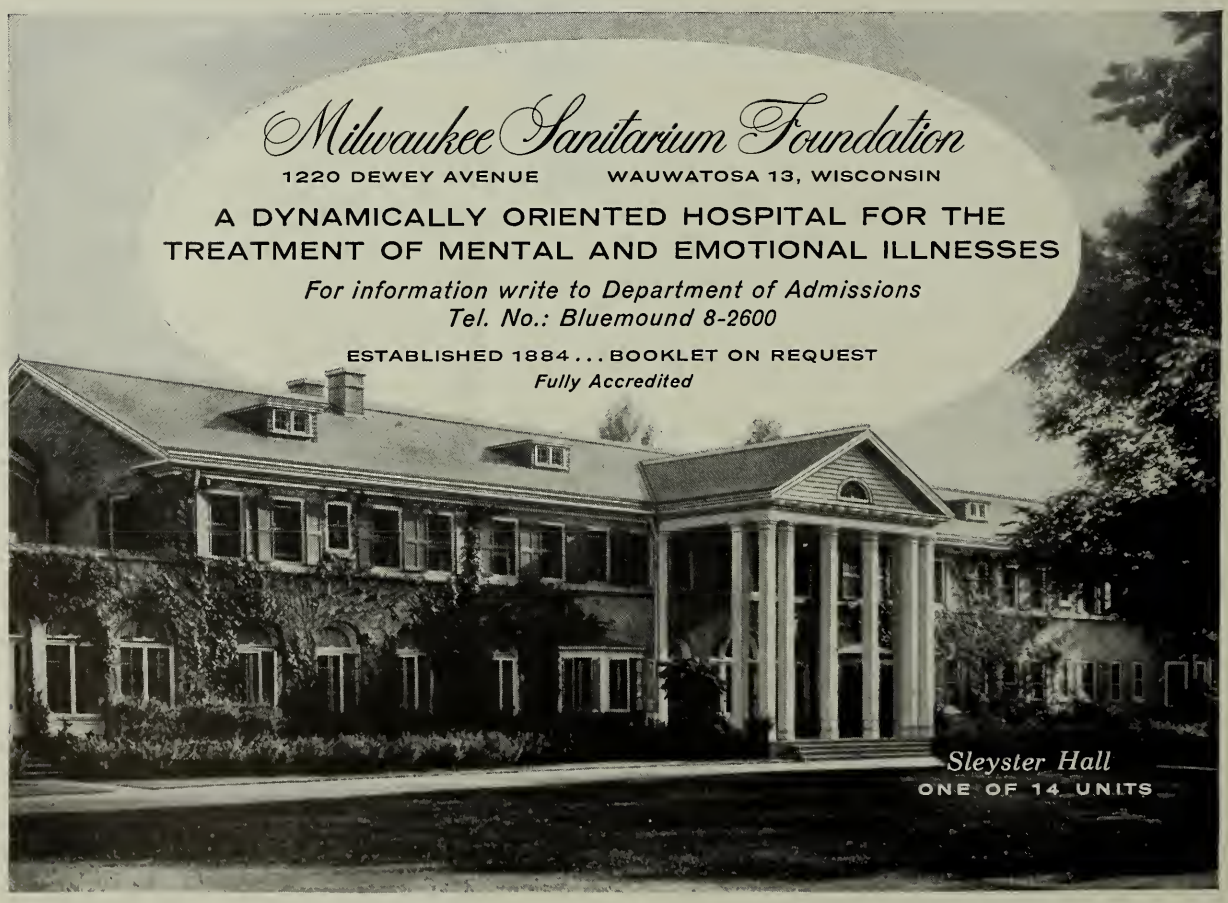
Across Capillary Wall. Edited by S. R. M. Reynolds and B. W. Zweifach. $4.50. Pp. 170. Urbana, University of Illinois Press, 1959.

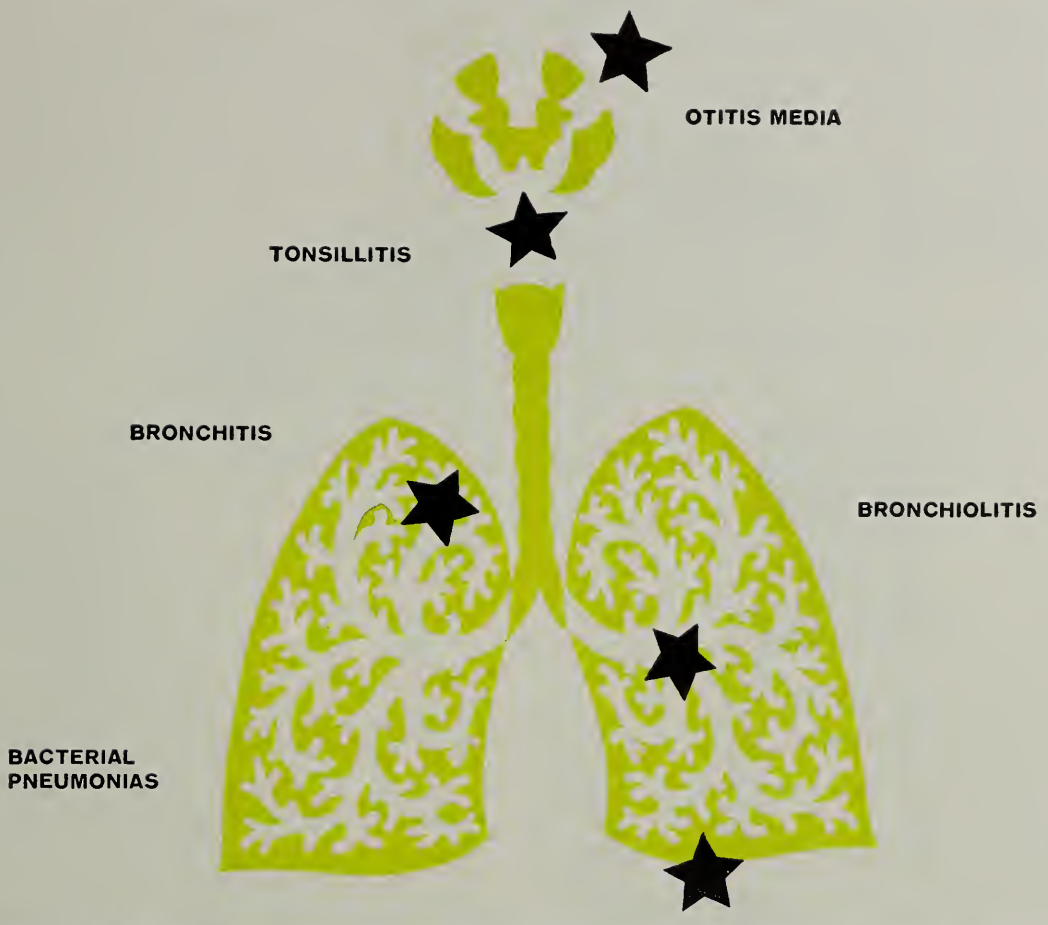
This volume reports the proceedings of the Fifth Conference on Microcirculatory Physiology and Pathology held on April 1, 1958. For some curious reason the afternoon session appears before the morning session. The eleven papers and various informal discussions that comprised the conference give the reader a good idea of the concepts and experimental approaches, now two years old, of investigators in this important basic field. Electron microscopy and the development of new physiological and biophysical techniques has opened up several new broad avenues of investigation of the capillary wall and the problem of how substances manage to get across, or perhaps more accurately, through the wall. All these studies indicate that the capillary wall and the factors concerned with the exchange of substances across it are much more complex and intriguing than was taught just a few years ago. Many interesting observations and speculations were presented at the conference. Obviously, however, much more work is needed, since agreement among the investigators on numerous important points was refreshingly absent.

David P. Earle, M.D.

Dupuytrens, a sign of cirrhosis

Dupuytren's contracture, a classic eponymic designation for many years, has taken on new significance since Wolfe and associates pointed out the high incidence of palmar contractures in a group of alcoholic patients with cirrhosis. Among other fascinating aspects of their study was the revelation that Dupuytren's first patient, on whom he operated, was a wine merchant. There have been numerous references in the past to the fact that Dupuytren's contracture did occur in patients with liver disease and various nutritional disturbances, but the lesion has now clearly emerged as a valuable diagnostic sign in Laennec's cirrhosis. Its pathogenesis is still quite obscure, and there is no clear-cut identification with postnecrotic or biliary cirrhosis. *Mahlon Delp, M.D., Robert T. Manning, M.D., and Robert W. Brown, M.D. Physical Signs of Cirrhosis. Postgrad. Med. Feb. 1960.*





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1. Lysaught, J. N., and Cleaver, W.: Proceedings of the Detroit Symposium on Antibacterial Therapy (Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959).

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Each pill is equivalent to one USP Digitalis Unit

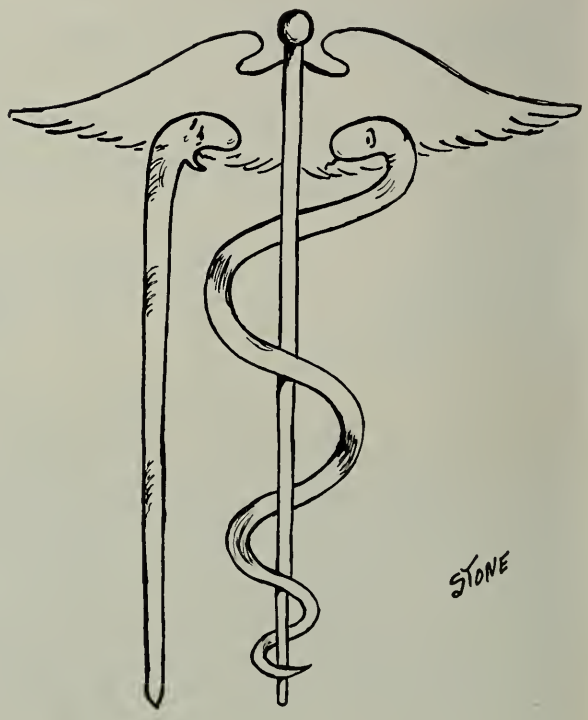
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Pills and pregnancy

The average expectant mother feels that she cannot deliver a healthy child if she does not take a pill, or several pills, two or three times a day. One is never asked about diet during pregnancy, but there are always numerous questions, such as "When are you going to give me my pills?"; "My friends are already taking their pills; when do I get mine?"; "Is it all right if I continue taking my vitamins, minerals, and iron?" Thus, to the patient, prenatal care is a pink pill, an orange or black pill, a red and white pill, or a blue pill. The working expectant mother usually carries her pills with her, and during the lunch hour the gestational group compares pills as to size, shape, color, and price. The pregnant female has been sold the idea that it is essential that pills be taken to assure a normal pregnancy. The physicians have not taken the time to convince patients that it is much better to have an adequate dietary intake, and to eat an adequate diet during the preconception, intrapartum, and postpartum periods. *Lawrence L. Hester, Jr., M.D. Prenatal Care—The Pale, Pink Pill. J. Med. A. Alabama. Nov. 1959.*



I've got a stiff neck



no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

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PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

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Correction, please

The good parts of accreditation are the tissue committee and the records committee. It is recommended that these should be adopted and improved upon. A doctor certainly does not like to get up continually and explain a normal pathologic report in staff. If his skin is thick or he is blind, someone ought to tell him that he is not fair either to his patients or to the reputation of the rest of the medical profession. He should be given a chance to correct himself. If he doesn't, action should be taken. But there is a better mechanism than that recommended.

As much attention should be paid to the records committee as to the tissue committee since an improperly treated fracture, a mismanaged burn, a diabetic acidosis, or any other medical condition can be discovered. Here, before anyone gets hostile, an attempt should be made to determine whether it is through ignorance, indifference, or willful exploitation that poor medicine has been practiced. *Roy E. Hanford, M.D. Practicing Jim Reviews Present Day Medical Practices with Certain Recommendations. Northwest Med. Dec. 1959.*



You DID tell me to bring a stool didn't you?

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An efficient suite for medical use is not just a group of rooms. It has to be engineered to make the best use of space. Erdman prefabricated medical offices are individually designed for the selected building site and with your specific needs in mind, just as we have done for more than 275 doctors throughout the country.

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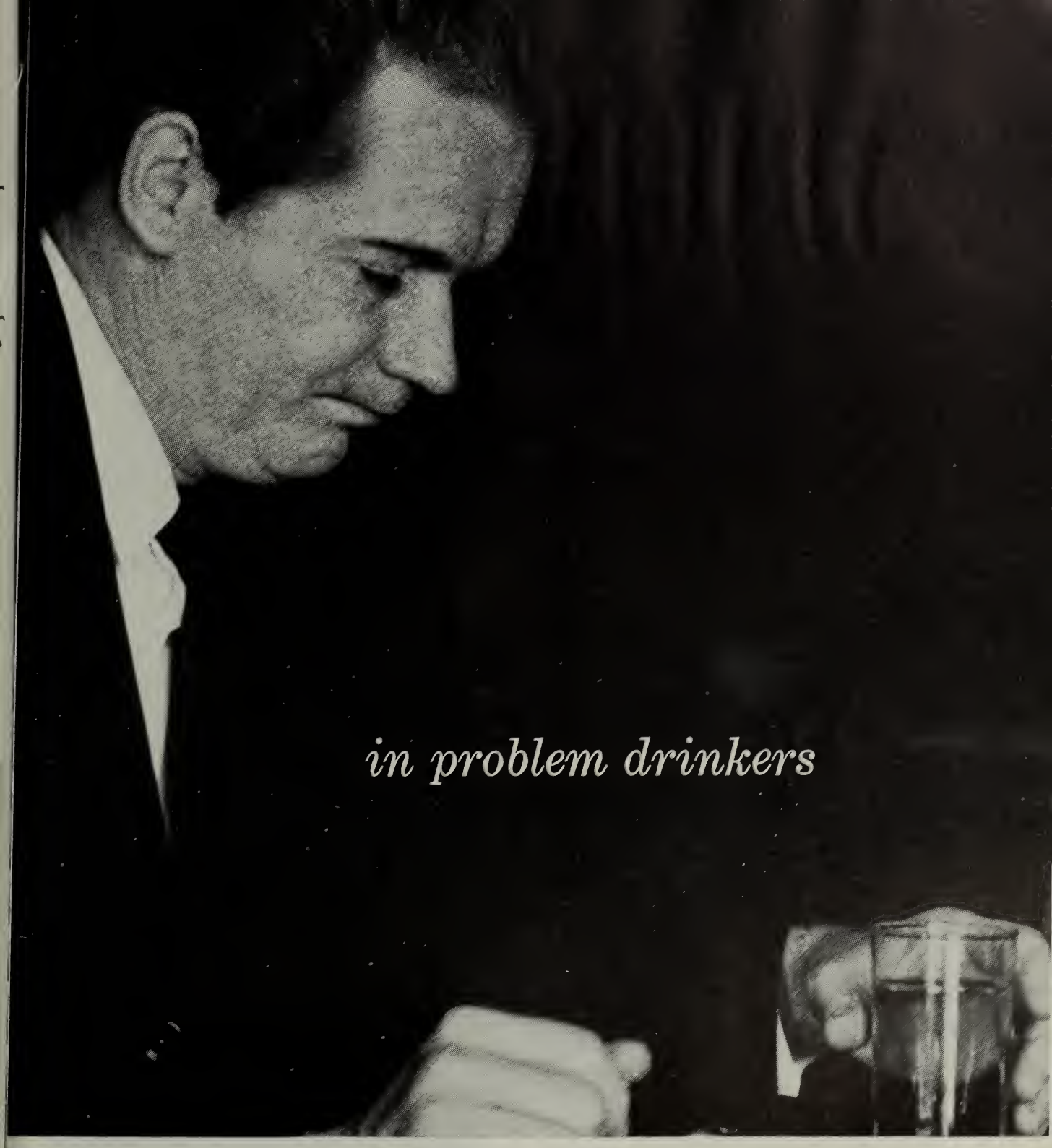
More research needed

Only long-term studies can indicate whether use of the sulfonylureas in place of insulin will influence the incidence, degree, and time of occurrence of the degenerative complications of diabetes. Whether or not one accepts the evidence indicative of a beneficial effect of close control of diabetes, with diet and insulin, on the incidence and age of onset of these degenerative complications, our present day therapy leaves much to be desired in terms of abolishing premature arteriosclerosis and diabetic neuropathy, nephropathy, and retinitis. The resurgence of interest in investigation of both the basic lesions of diabetes and the action of insulin, stimulated in large measure by the introduction of the sulfonylureas, should result not only in development of new oral agents for treatment of the malady but in more understanding of the pathogenesis of the long-term complications of diabetes and of therapeutic measures which will be effective in preventing their appearance or halting their progression. *Irving Singer, M.D. Critique of Oral Hypoglycemic Agents. J. Louisiana M. Soc. Jan. 1960.*



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maintains tranquility

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Professional literature available on request from the Medical Department, Pfizer Laboratories, Div., Chas. Pfizer & Co., Inc., Brooklyn 6, New York

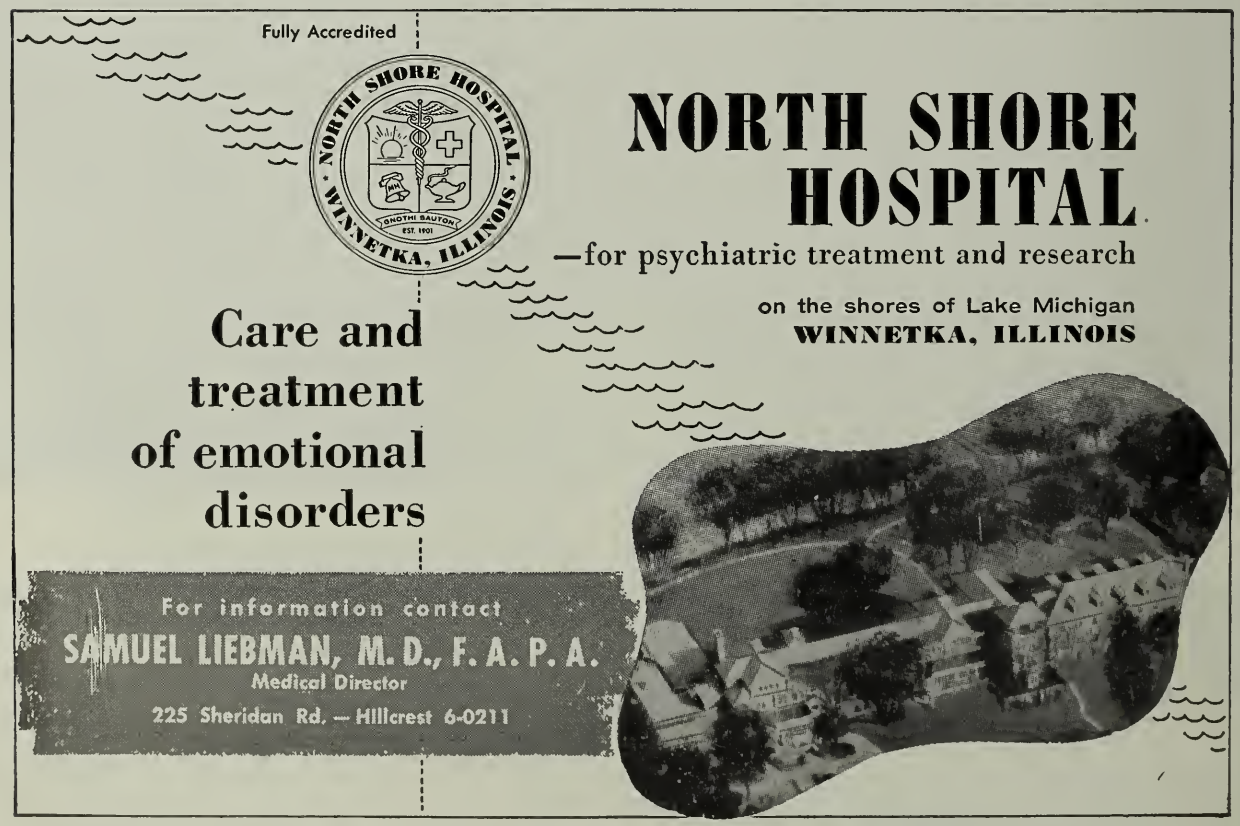
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Meeting a cardiac emergency

Paroxysmal ventricular tachycardia is the most serious disorder of this group, since its natural progression is to ventricular fibrillation and death. It occurs almost invariably in severely diseased hearts or as a manifestation of digitalis intoxication. At a rate of 150 to 220 beats per minute, the rhythm may appear superficially to be regular, but comparison of minute-to-minute counts will reveal definite irregularity. The first heart sound at the apex is widely split, due to ventricular asynchrony, and may be variable in intensity, due to independent atrial activity. Carotid sinus pressure has no effect. Pronestyl,® which is safer and more effective than quinidine, should always be on hand for treating this emergency. The dosage is 100 mg. (1 cc.) intravenously every minute until the arrhythmia is abolished. The practical limitation on dosage is 1,000 mg., but a higher dosage may be required in a few critical cases. Electrocardiographic monitoring to detect significant lengthening of the QRS interval is a very important guide to toxicity. When frequent premature ventricular contractions occur in the course of an acute myocardial infarction, administration of Pronestyl, 250 mg. every six hours orally or intramuscularly, should be started immediately, unless the specific contraindication of AV dissociation is present. *Francis B. Tiffany, M.D. Diagnosis and Treatment of Cardiac Emergencies. J.-Lancet Jan. 1960.*

Seeing the brighter side

Elderly persons with macular degeneration can learn to live with this exasperating vision. When they realize that they are still able to discern the food on their plates, see most of their grandchildren, and move around objects and through doorways easily without bumping into things, their apprehension diminishes. The physician should take time to reassure elderly patients that looking at television, trying to knit, gardening in the bright sunshine, working under fluorescent lights, and using their eyes even though they are physically tired will not cause any harm. *Malcolm A. McCannel, M.D. Some Common Misconceptions about the Eyes. Postgrad. Med. Feb. 1960.*



Tetracycline Phosphate Complex (TETREX®)
U.S. PAT. NO. 2,791,609
in the Therapy of PNEUMONIA

Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in bacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among bacterial pneumonias, based on such clinical grounds as speed of onset, sepsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or gram-positive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pneumococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative *Hemophilus influenzae* and *Klebsiella pneumoniae*. Although *K. pneumoniae* causes only about 1 to 2 per cent of pneumonia cases on the average,[1] these are apt to be acute and fulminating (Friedländer's pneumonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except by gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reaction. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

Tetracycline is also clinically effective in primary atypical pneumonia.[3]

The tetracyclines (e.g., TETREX) have the advantage of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient. antibiotics are not considered as substitutes for the individual evaluation. clinical observation and judgment of the physician.

Some Micro-organisms Susceptible[a] *to Tetracycline* (TETREX)[b]

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; Ps. aeruginosa; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

a Some strains are not susceptible.

b Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics. 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

References: 1. Wood, W. E., Jr.: In: A Textbook of Medicine. Edited by Cecil, R. L., and Loeb, R. F., 9th edition, Philadelphia, W. B. Saunders Co., 1955, p. 145. 2. Welch, H.; Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (Dec.) 1957. 3. Keefer, C. S.: The choice of an anti-infective agent. In: Drugs of Choice, 1958-1959. Edited by Walter Modell, St. Louis, The C. V. Mosby Co., 1958, p. 135.

BRISTOL LABORATORIES INC., SYRACUSE, NEW YORK

Controlling postanesthetic nausea

The site, type, and duration of the operation were found to be important factors in influencing the rate of postanesthetic emetic symptoms. Upper intra-abdominal procedures involving the stomach, duodenum, and gallbladder were associated with the highest rate of nausea, retching and vomiting, while perineal and extremity operations were followed by the lowest incidence of emetic symptoms. The longer the time required to complete the operation, the greater the rate of emetic symptoms.

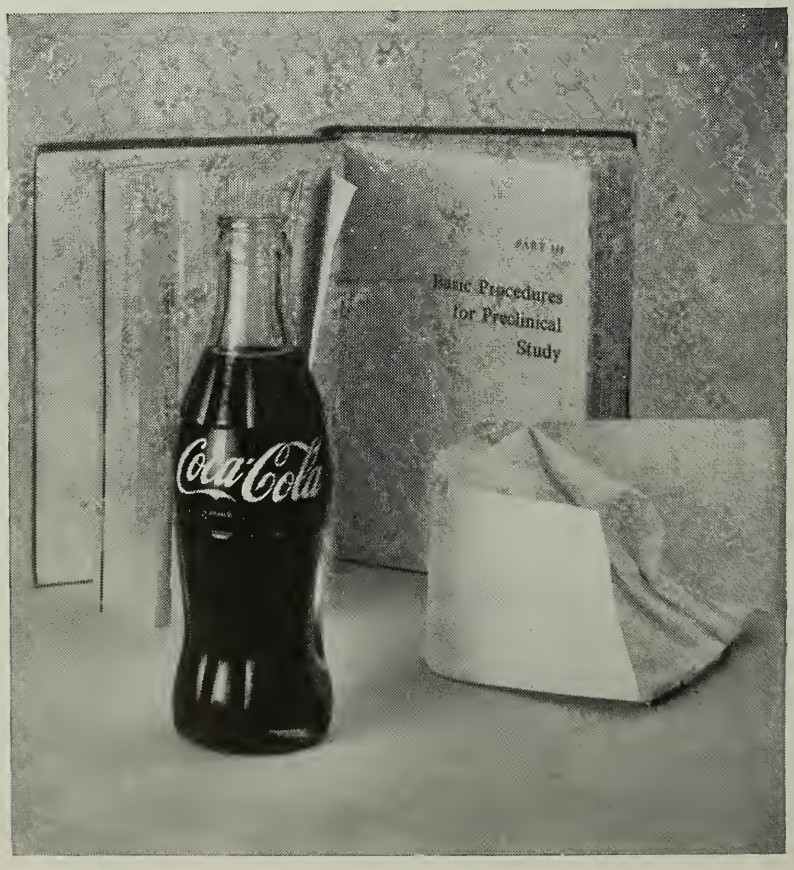
In this group of patients, females experienced emetic symptoms one and one-half times more frequently than males. The lowest incidence occurred in the group aged 40 to 60 years.

A controlled study to evaluate the effectiveness of Marezine® with placebo, administered as a suppository by the rectal route to provide relief of emetic symptoms, was carried out in 554 of the patients who experienced these symptoms. The results indicated that Marezine is highly effective in ameliorating the symptoms, for it produced complete or partial relief in approximately 93 per cent of the patients, as compared with 60 per cent of the patients who obtained similar degrees of relief with the placebo suppository. This beneficial effect is accomplished with a minimal incidence of side-effects, and, therefore, can be considered as a definite aid to the patient, as well as to the surgeon and the anesthesiologist. *John J. Bonica, M.D., William Crepps, M.D., Benjamin Monk, M.D., and Blair Bennett, Ph.D. Postoperative Nausea and Vomiting. West. J. Surg. Nov.-Dec. 1959.*

Society and the scientist

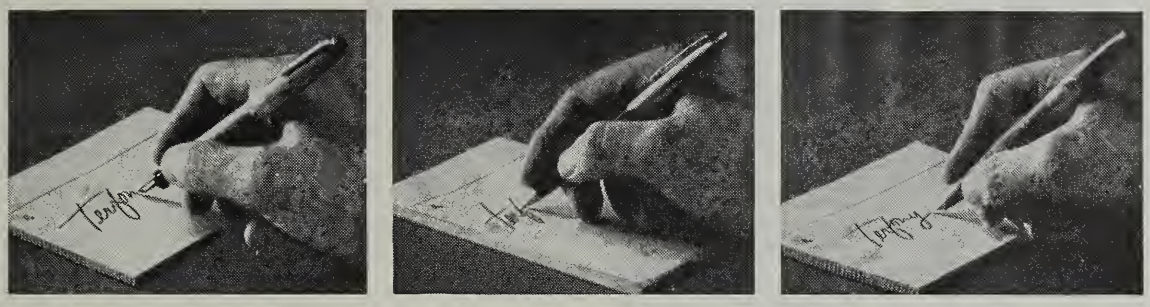
It must be admitted that there are obstacles to individual [research] action in our age which did not exist at earlier times. Galileo could make his own telescope. But once when I was talking with a very famous astronomer, he explained that the telescope upon which his work depended owed its existence to the benefactions of enormously rich men, and, if he had not stood well with them, his astronomical discoveries would have been impossible. More frequently, a scien-

(*Continued on page* 80)

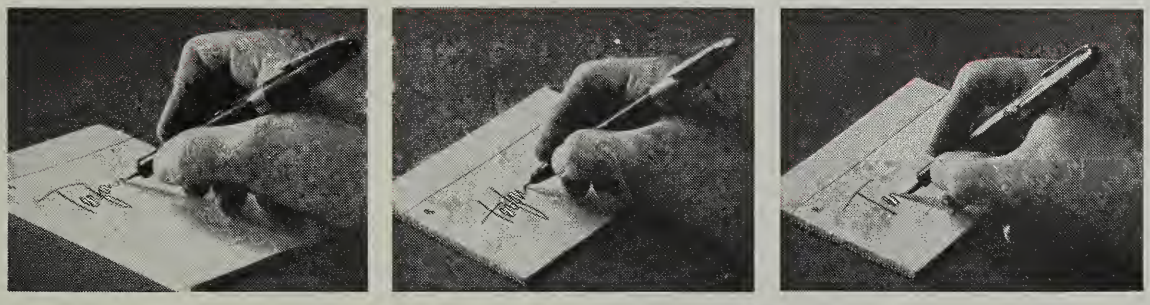


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tist only acquires access to enormously expensive equipment if he stands well with the government of his country. He knows that if he adopts a rebellious attitude, he and his family are likely to perish along with the rest of civilized mankind. It is a tragic dilemma, and I do not think that one should censure a man whatever his decision; but I do think—and I think men of science should realize—that unless something rather drastic is done under the leadership or through the inspiration of some part of the scientific world, the human race, like the Gadarene swine, will rush down a steep place to destruction in blind ignorance of the fate that scientific skill has prepared for it. *Bertrand Russell. The Social Responsibilities of Scientists. Science. Feb. 12, 1960.*



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Effect of temptation on changes in attitude

The theory of cognitive dissonance holds that when a person is forced to do or say something in disagreement with his privately held opinion, there will be a tendency for opinion to change in such a way as to bring it into correspondence with the act performed. Secondly, the greater the pressure used to induce the discordant act, the less will be the tendency to change opinion. In an experimental test of this theory, changes in moral attitudes following either cheating on a test or refraining from cheating were investigated. A sample of students were offered a prize for good performance on a test and were given an opportunity to cheat. Those who did not take advantage of the opportunity and did not cheat became more severe in their attitudes toward cheating, while those who did cheat became more lenient. The greater the motivation to cheat (tested by varying the value of the prize), the greater each of these effects was. This study is one of the first to explore the consequences when an individual is faced with the decision to comply with or violate a standard and, if verified by further research, will increase our ability to predict human behavior. *National Science Foundation, 9th Annual Report, 1959.*

True hypertensive heart disease

It seems that the actual number of cases of true hypertensive heart disease without any obvious clinical component of coronary artery disease is becoming much more unusual, and this is probably due to the increased efficacy of the antihypertensive drugs. Certainly nothing new except more potent antihypertensive drugs has been added to the physician's armamentarium, and the treatment of hypertensive heart disease, of course, is just simply the control of essential hypertension and other forms of secondary hypertensive disease. The more accurate recognition of the latter group, such as unilateral renal disease, pheochromocytoma, and primary aldosteronism has removed a small percentage of these cases from the realm of the internists, but the vast majority of hypertension is still probably of the so-called "essential" type and is managed almost exclusively by the internists. Sympathectomy

(*Continued on page* 84)

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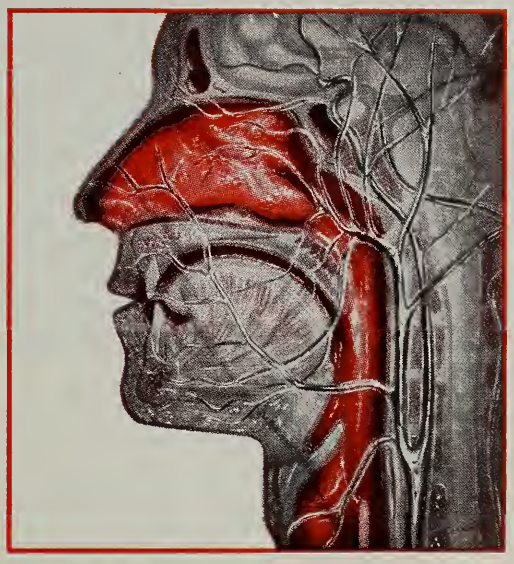
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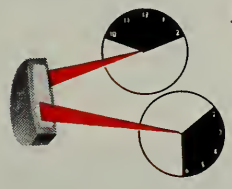
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- transported systemically to *all* respiratory membranes
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Relief is prompt and prolonged because of this special timed-release action:



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Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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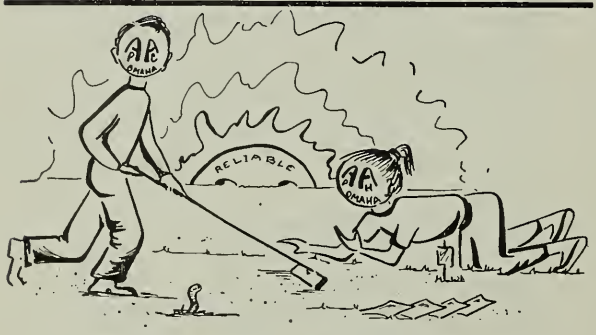
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seems to have faded away completely in the last ten years, and the other reasonable adjuncts to management such as weight reduction, and handling emotional problems of the patient are still of great value in this disease. *Joseph P. Melvin, Jr., M.D. Recent Advances in Cardiovascular Disease. J. Mississippi M. A. Feb. 1960.*

Eh . . . .?

Patients should be told to acquire a new habit. Instead of saying, "What?" "I didn't hear you," or even "Please repeat that," they should say "Please repeat that slowly and distinctly." Why should the speaker be asked to speak slowly? There are two reasons. First, in most elderly patients, there is some slowing of the mental processes. In relation to hearing, Dr. Raymond Carhart of Northwestern University has called this by the expressive term "phonemic regression." By whatever name it is called, it is present and slower speech is comprehended better. Second, the listener is often confronted with the problem of distinguishing between words that sound very similar. He needs a fraction of a second to resolve this puzzle. If speech is coming too fast while the listener is resolving his difficulty, three or four more words will have been said to which he cannot pay attention. He misses these, and the whole sentence is lost. Slow speech may give him time to solve the problem of the two similar words, and he will be ready to listen to the additional three or four. *Gordon D. Hoople, M.D. Care of Hearing in the Elderly. Geriatrics Feb. 1960.*

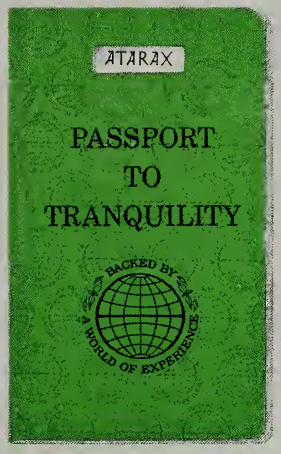
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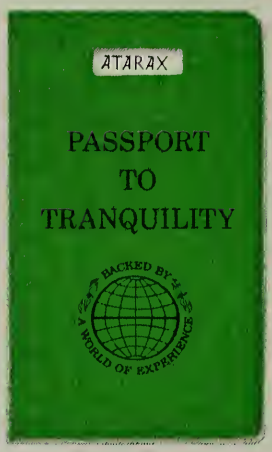
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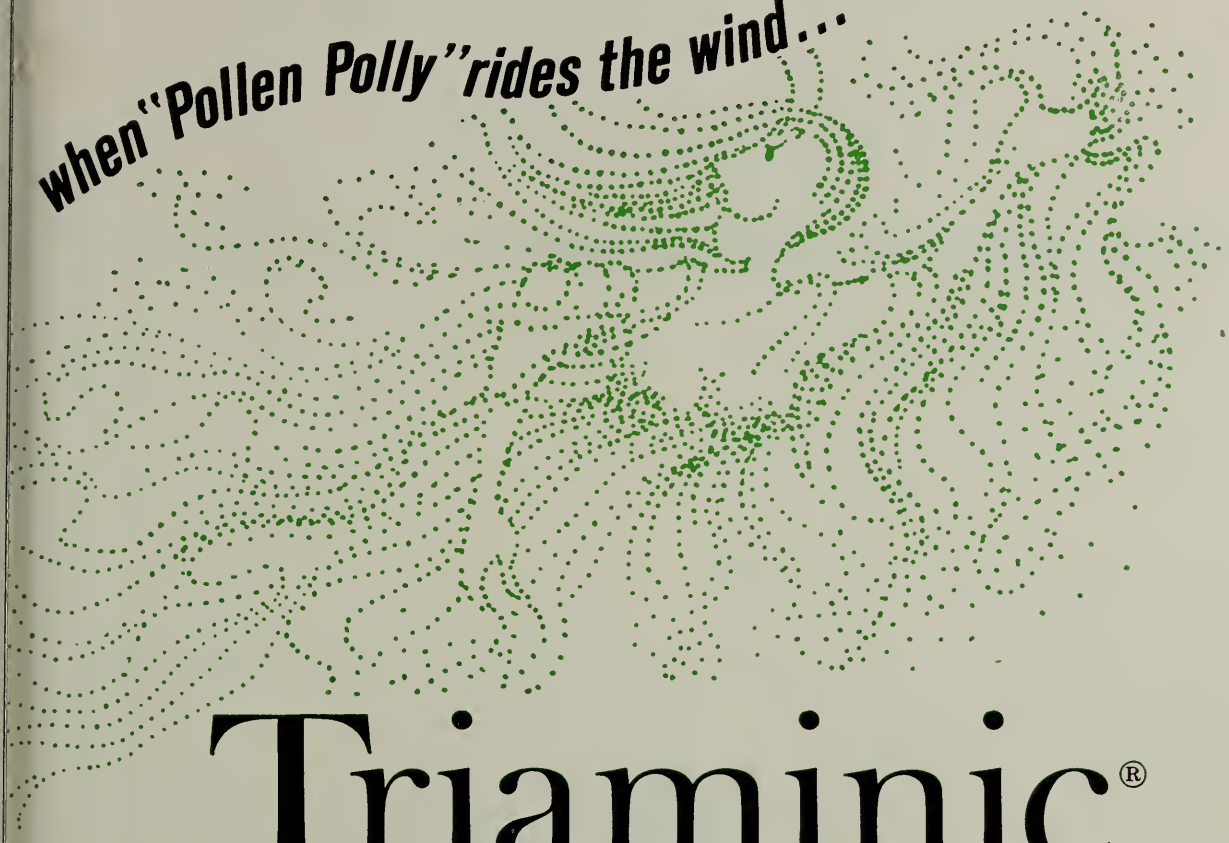
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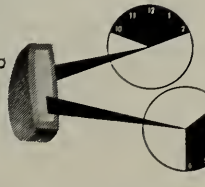
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The Month in Washington



Washington, D.C. — Defeat of the Forand Bill in the House Ways and Means Committee highlighted developments on the issue of legislation to provide more Federal health eare for the aged. The committee voted 17 to 8 on March 31 to shelve the bill which would increase Social Seeurity taxes to provide surgical benefits and limited hospitalization and nursing home care for Social Security beneficiaries, exeept the disabled.

However, the issue remained very much alive.

The Eisenhower Administration and Congressmcn were separately considering various alternative proposals to provide additional health care for the aged, but outside the Social Security system. And the action of the House Committee did not rulc out the possibility of Forand-type legislation being brought up in the Senate later this session.

The House Committee vote against thc Forand Bill eame during the drafting of an omnibus measure of revisions in the Social Seeurity program. The committce voted tentatively to bring physicians under Soeial Security.

The eommittec also favored climination of the requircment that a disabled person must be 50 years or older to bc eligible for Social Security payments.

Arthur S. Flemming, seeretary of Health, Education and Welfare, said thc Administration was considering a plan for Federal payments to the states to help needy old persons buy private health insurance on a voluntary basis. He said he hoped the plan would be ready for submission to Congress by late April.

Sen. Jacob K. Javits (R., N.Y.) and seven other Republican Senators introduced similar legislation in the Senate. The bill called for the Federal governement and states jointly putting up about $1 billion a year to help persons 65 years and older, and their spouses, to buy private health insuranee. The coverage would include physicians' care in home and office, diagnostic serviees, hospitalization, and nursing home care.

Another plan being considered by some other members of Congress would broaden the Federal-State public assistanec program to provide more health care for needy older persons.

Both President Eisenhower and Vice President Nixon reiterated their opposition to any eompulsory health plan such as the Forand Bill. The Presidcnt told a news conferenec that sueh plans would be a definite step toward socialized medieine and proposed that medical care for the aged be improved through further development of voluntary health insurance programs.

Vice Presidcnt Nixon gave his position in a letter to physieians who had communicated with him about the matter.

"The Vice President, throughout his earcer as a publie official, has consistenly opposed and will continue to oppose any eompulsory health insurance program," the letter said. "This, of eourse, includes the Forand Bill. . . ."

(*Continued on page* 26)

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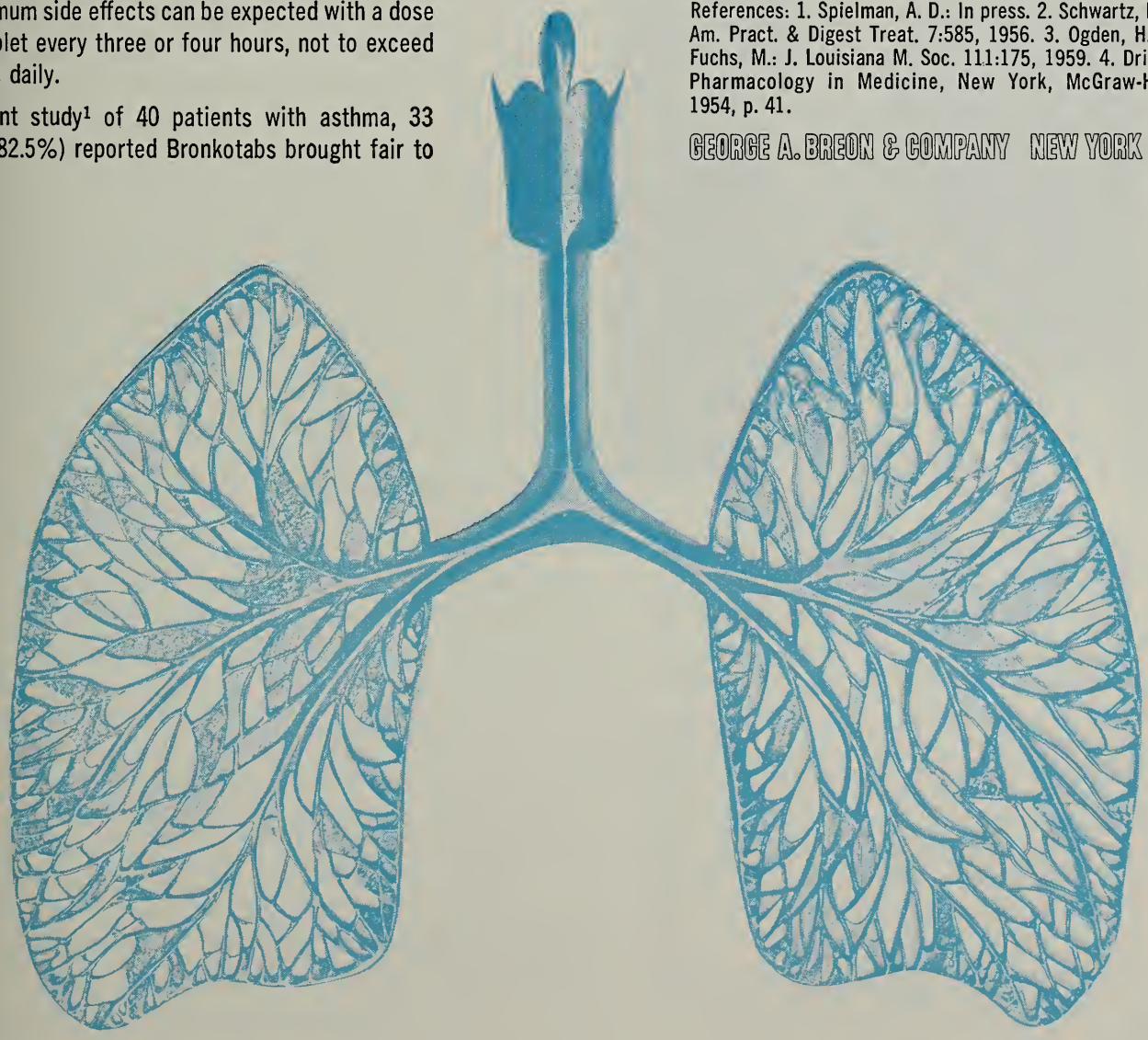
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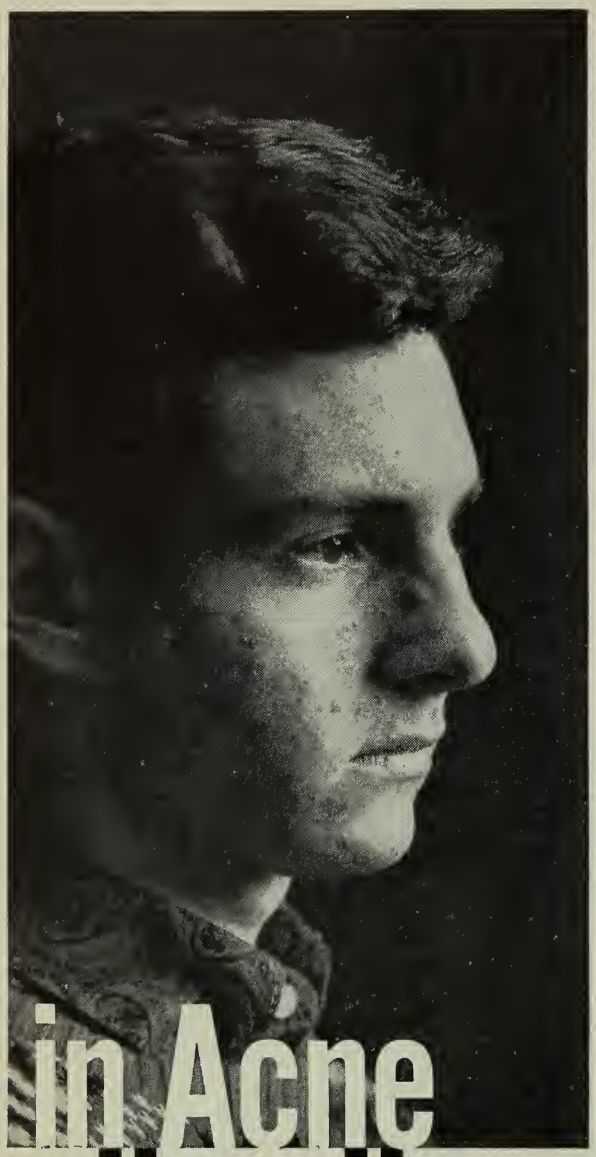
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1. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: *Brit. M. J.* 2:606, Oct. 3, 1959. 2. Hodges, F. T.: *GP* 14:80, Nov., 1956.

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WASHINGTON (Continued)

"He believes that the best way to handle the problem of people over 65 who do not have and cannot afford health insurance is through a program which will enable those who desire to do so to purchase health insurance on a voluntary basis."

On the other side, three candidates for the Democratic nomination for President—Sens. John F. Kennedy (Mass.), Hubbert H. Humphrey (Minn.) and Stuart Symington (Mo.)—said they would push for passage of Forand-type legislation.

The AFL-CIO continued its all-out campaign in support of the Forand Bill. Leaders of the labor union repeatedly attacked the American Medical Association for opposing the bill.

One of the attacks prompted Dr. Louis M. Orr, Fla., to protest in a letter to AFL-CIO President George Meany against the union's "deliberate distortions of the truth, perversions of the truth, and outright untruths."

Dr. Orr charged that allegations in a political memorandum of the AFL-CIO's Committee on Political Education (COPE) "not only . . . attempt to impugn the motives and competence of the nation's physicians, but they seek to mislead labor's rank and file, the members of Congress, and the American people as a whole."

"When the AMA opposes any legislative health measure, it does so because its members believe that it would lead to poorer—not better—health care for the people of this country," Dr. Orr said.

Senate Republican Leader Everett M. Dirksen (Ill.) also defended the AMA as well as the Eisenhower Administration, against the attacks when AFL-CIO leaders repeated them in testimony before the Senate Subcommittee on Problems of the Aged and Aging.

Dr. James A. Appel, Lancaster, Pa., a member of the AMA Board of Trustees, testified before the Senate Subcommittee that the greatest health problem faced by older people is "their isolation from the rest of society." He said:

"The health problems of the aged can only be solved within the context of total health. They involve far more than hospitals or a doctors' care. They involve the older person's other re-

(*Continued on page 39*)



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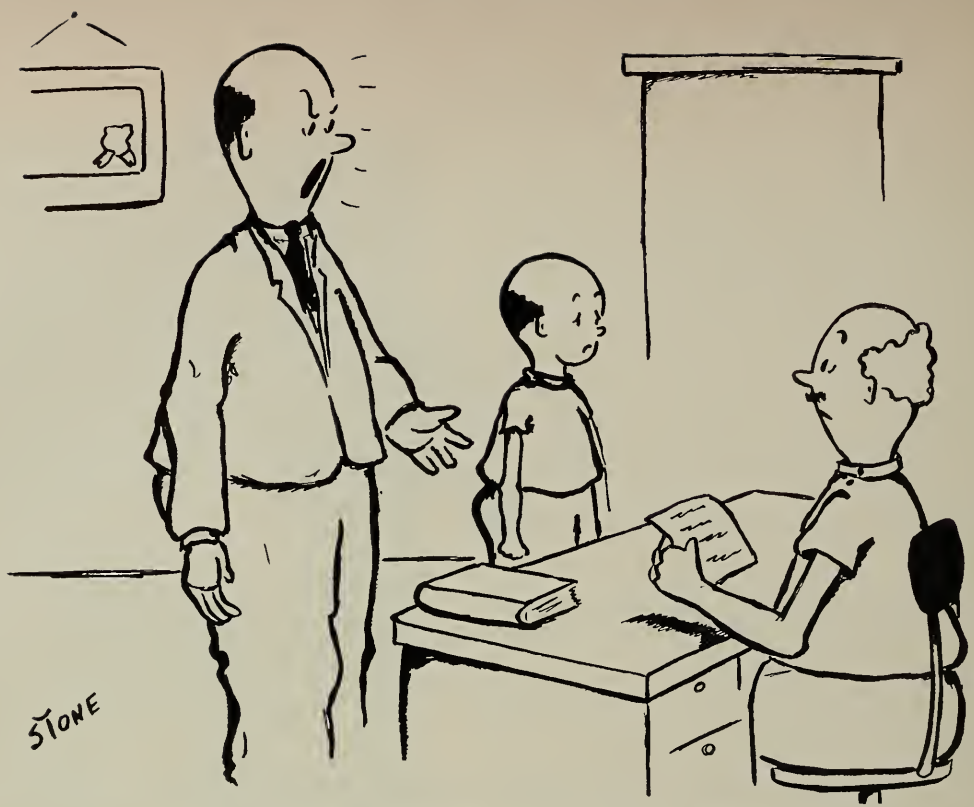
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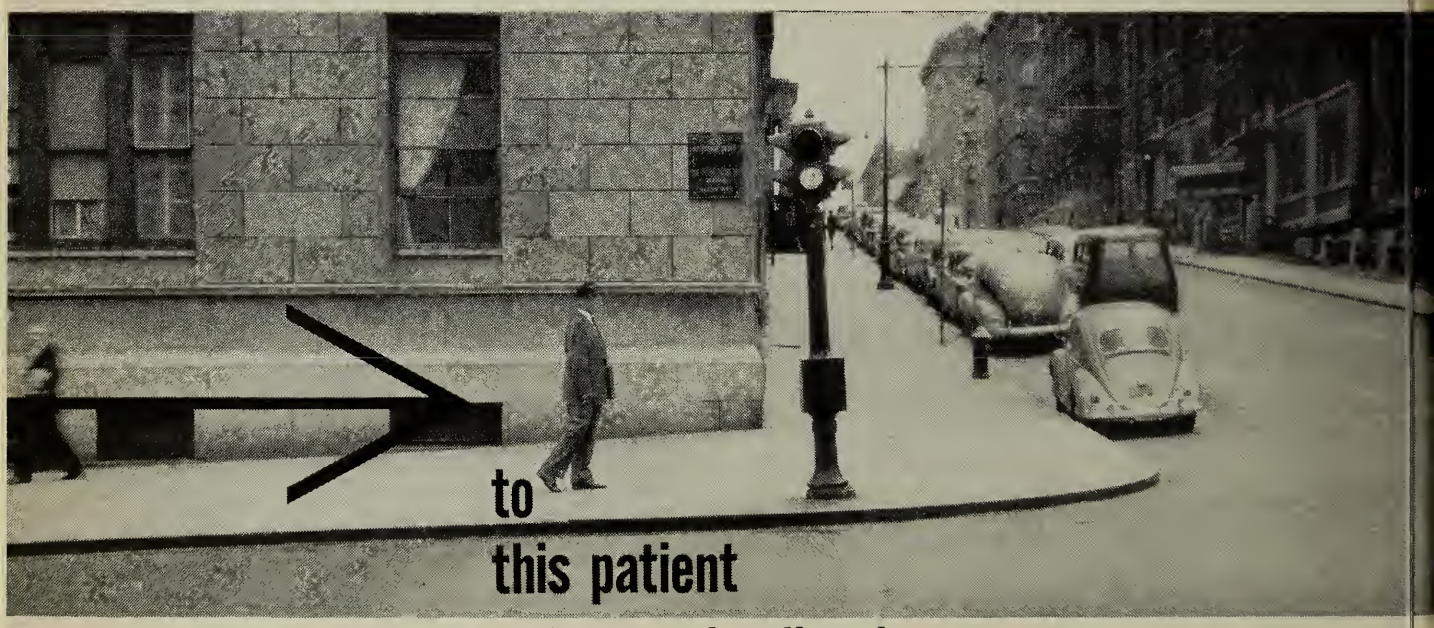
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WASHINGTON (Continued)

quirements in life, whether these be housing, recreation, community understanding and acceptance, the right to be useful, the courtesy of being treated as individuals, or the opportunity of living as self-reliant, respected members of society."

As for an aged person being denied medical care because of a lack of money, Dr. Appel said emphatically. "Medical care is available to every man, woman, and child in the United States regardless of his or her ability to pay for it. That care is not now denied, nor will it be denied."

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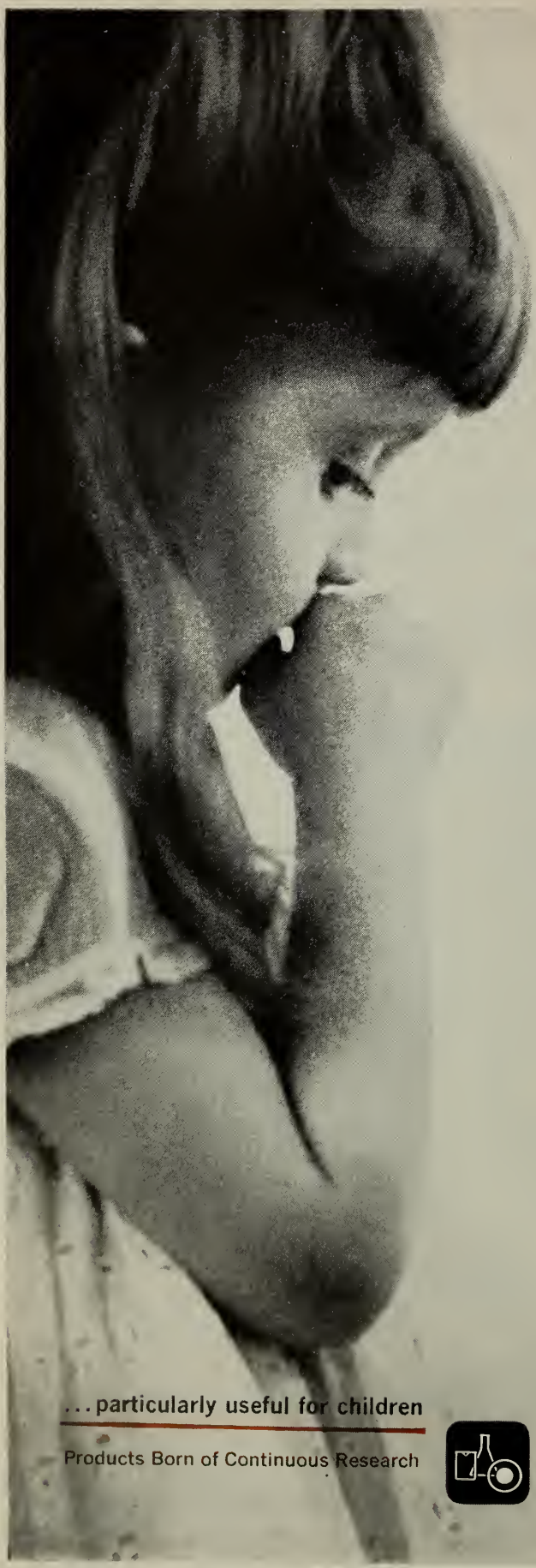
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1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

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Evaluation of Older Patients for Cardiac Surgery*

Robert O. Brandenburg, M.D., *Rochester, Minnesota*

In the past decade, thousands of patients with congenital or acquired heart disease have been helped or cured by cardiac operations. During the early part of the decade, the great majority so treated were less than 45 years of age. More recently, larger and larger numbers of patients in the 45-65 age group or even older have undergone corrective surgical procedures successfully.

The selection of older patients for cardiac operations places considerable responsibility upon the physician. How does he properly and with good conscience advise these people? There are no rules that govern every situation, but the physician should be able to advise his patient intelligently with the following information and concepts in mind: 1. He must know the natural history of the disease. 2. He must be able to assess the stage of the disease present. 3. He must have knowledge of the surgical risk based on his experiences with this lesion. 4. He should know whether palliation or cure is likely after surgical intervention.

A preliminary word regarding coronary atherosclerosis appears in order. My surgical colleagues at the Mayo Clinic are not treating this disease, and we still do not believe there is any evidence to indicate alteration in the course of the disease as the result of surgical treatment. However, no doubt it is true that a variety of surgical procedures may ease or relieve anginal pain in certain patients. The advancement of techniques for coronary arteriography, enabling the accurate assessment of the coronary circulation, gives promise of definitive and improved surgical procedures in the future.

This discussion will be devoted mainly to congenital and rheumatic cardiac lesions in patients 45 years of age and older.

Congenital cardiac lesions

Atrial Septal Defect: The most common congenital lesion in such patients is atrial septal defect. In evaluating this lesion with regard to surgical treatment, we must keep in mind the relatively benign nature of the anomaly and balance this against the low surgical mortality rate of two per cent when the condition is uncomplicated. As a result of this extremely low surgical risk, most younger patients with this lesion are now advised to have surgical treatment when the diagnosis is made. In general, this is true up into the sixth decade of life. Many patients with such defects are relatively well until the fourth or fifth decade, when they develop progressive and disturbing symptoms of effort fatigue, palpitation, and dyspnea. Patients in the fourth, fifth, and sixth decades especially

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are likely to be greatly benefited symptomatically and generally by operation.

Operation is absolutely contraindicated only in those patients who have no increase or a decrease in pulmonary blood flow as compared to systemic flow. Operation does not appear to be justified in patients in the seventh and eighth decades who are relatively asymptomatic. However, in symptomatic patients in the seventh decade, operation is indicated in selected instances. Five patients who were 60 to 67 years of age, and who had moderate to severe symptoms, have undergone surgical repair at the clinic without mortality.[1] Four of the five have experienced excellent results; the other has continued to require a regimen for congestive heart failure but is improving.

It is important in surgical evaluation to differentiate patients with ostium secundum defects from those with defects of the atrioventricular canal which, in the incomplete form, commonly are called "ostium primum" defects. All of these latter defects should be repaired by operation on the open heart, while secundum defects can be repaired satisfactorily by a variety of techniques. This differentiation can be done best by electrocardiography. The electrocardiogram in secundum defects discloses incomplete right bundle-branch block or diastolic overloading of the right ventricle with right axis deviation. The primum defects are associated with an identical picture from the right precordial leads but with left axis deviation. The frontal-plane vectorcardiogram particularly discloses striking differences between the two types of lesions.[2]

Diagnosis and surgical repair of these interatrial communications in middle-aged and older patients who have symptoms have been among the most gratifying advances in the past seven or eight years.

Other Congenital Lesions: Other congenital cardiac lesions are uncommon in patients more than 45 years of age. Most of those seen are patent ductus arteriosus, coarctation of the aorta, and pulmonic stenosis or ventricular septal defect or both.

Patients over 40 with ventricular septal defects associated with normal right ventricular pressures usually are not advised to have surgical treatment, since the defect is small and the only significant risk apparently is that of subacute bacterial endocarditis. This likelihood is remote. We have not operated on any patients with this lesion who were more than 45 years of age.

Patent ductus arteriosus occasionally is the cause of heart failure in middle-aged and older patients, especially women. Surgical treatment is advisable in such cases. In the absence of evidence of cardiac enlargement or cardiac symptoms, however, operation is not advisable.

Coarctation of the aorta after 40 presents increased surgical hazards. Such patients often have extremely atherosclerotic aortas, making surgical repair more difficult. Nevertheless, surgical treatment usually is warranted well into the sixth decade unless other serious complicating features are present or the lesion is mild. Most patients with this lesion who have had surgical treatment after 40 have been women.

Aortic valvular lesions

Surgical treatment of aortic stenosis, both congenital and acquired, has been a controversial subject. Surgeons continue to repair this lesion by a variety of techniques, such as closed procedures, open methods, or repair from above or below. It is now the consensus that open repair is advisable for the congenital lesion. For the calcareous lesions seen in older patients, many techniques continue to be employed. Our cardiac surgeons have used all the proposed methods, but in the past 12 months all such patients have been operated on by open methods, employing extracorporeal circulation. Thus far we have been impressed with the lessened morbidity and mortality rates and the improved results associated with this approach. We recommend operation for this lesion only in the presence of definite and progressive symptoms. The reasons for this are obvious, in that the operation is palliative only and has been associated in the past with a significant surgical risk. While this lesion may well be tolerated for years, once symptoms develop, the condition commonly worsens rapidly and progresses to death despite medical treatment. Hence we believe open operation is advisable in patients who have definite and progressive symptoms.

Aortic insufficiency has posed an even more difficult problem with regard to surgical treatment. While insertion of a Hufnagel valve has palliative qualities, complications frequently are associated with its use. In the past 18 months, we have stopped recommending this procedure

and, in selected patients with serious and progressive symptoms, have employed a direct operation, using extracorporeal circulation. In most instances, this has been the bicuspidization procedure, consisting of resection of the noncoronary cusp of the aortic valve together with the associated section of aorta, thus converting it to a bicuspid valve. Repair of perforation of a cusp subsequent to bacterial endocarditis has been possible in a few instances.

While these direct operations for aortic insufficiency are associated with a significant surgical risk, the long-term outlook without treatment in patients selected for operation is extremely poor; hence we believe operation is advisable. The results in some patients have been gratifying and dramatic, whereas in others they have been disappointing. Not enough time has elapsed to evaluate the long-term results.

Mitral valvular lesions

Mitral stenosis continues to be seen in older patients. Age alone, even into the seventh decade, does not necessarily contraindicate surgical treatment, although the operation rarely is necessary in this age group. Valvular calcification and resultant immobility appear to be greater in older patients, but this is not invariably true. Some younger patients have severe calcification and immobility of the valve and hence show little improvement from operation, while an occasional older patient with severe symptoms has relatively pliable valves. A sharply accentuated first sound at the cardiac apex and an "opening snap" are reassuring signs of valvular mobility increase the likelihood of a good surgical result.

Most cardiologists agree that class I mitral stenosis, at any age, does not justify operation. Class II stenosis in younger patients usually warrants operation, but the operation should be deferred in patients more than 45 years of age who have mild but nonprogressive symptoms. If symptoms are progressive, however, operation is advisable. Surgical treatment is always advisable for patients with class III and IV stenosis unless there are other serious complicating cardiac or extracardiac problems.

Mitral insufficiency is most commonly associated with mitral stenosis. Only in the past decade has it become appreciated that mitral insufficiency may be a pure lesion, or nearly so, and that it can cause serious and progressive symptoms. It is only since the advent of bypass surgical techniques that promising corrective procedures have been developed. Somewhat more than a year ago, selected patients who had progressive and serious symptoms caused by pure mitral insufficiency were subjected to open operations.[3] The results frequently have been gratifying, particularly in those with destructive lesions such as ruptured chordae tendineae and septal perforations. More recently, patients with elements of both stenosis and insufficiency of significant degree have been selected for surgical treatment. They have presented a somewhat more difficult problem because of valvular immobility. A complete new prosthetic valve undoubtedly will be necessary in some of these patients. Such valves are not yet perfected but it appears likely they will be available.

We continue to see an occasional patient more than 40 years of age who has serious combined rheumatic mitral and aortic valvular disease. The technical problems involved in the open repair of two grave valvular lesions continue to be serious and the risk is high. New techniques, such as the use of profound hypothermia, may be applicable to such patients in the future.[4]

Other lesions

Constrictive pericarditis or cardiac tamponade caused by pericardial effusion is not rare in patients over 40 and always should be considered as a cause of indeterminate congestive failure, since surgical treatment may be dramatically curative.

Conclusion

I wish to emphasize the importance of considering surgical treatment at any age for patients who have congenital or rheumatic or some other acquired cardiac lesions, if evidence of significant and progressive hemodynamic disturbance is present.

REFERENCES

1. Ellis, F. H., Jr.; Brandenburg, R. O.; and Swan, H. J. C.: Defect of the Atrial Septum in the Elderly: Report of Successful Surgical Correction in Five Patients Sixty Years of Age or Older, New England J. Med. (In press.)
2. Toscano-Barbosa, Ely; Brandenburg, R. O.; and Burchell, H. B.: Electrocardiographic Studies of Cases with Intracardiac Malformation of the Atrioventricular Canal. Proc. Staff Meet., Mayo Clin. 31:513-523 (Sept. 19) 1956.
3. Ellis, F. H., Jr.; Brandenburg, R. O.; Callahan, J. A.; and Marshall, H. W.: Open Heart Surgery for Acquired Mitral Insufficiency, A.M.A. Arch Surg. 79: 222-236. (Aug.) 1959.
4. Kirklin, J. W.: Personal communication to the author.

Management of Acute Myocardial Infarction

Theodore Zane Polley, M.D.*, *Joliet*

Acute myocardial infarction is but a stage of a disease process that is precipitated by at least three important factors: diet, disorders of blood lipids and lipoproteins, and heredity. Possibly other contributing factors are mesomorphic types and time.

The occurrence of acute myocardial infarction is a spontaneous event in the course of arteriosclerosis.[10] In my experience, which encompasses a large cross section of an urban and farming community, there is no significant variation in occurrence other than that reported by Schnur in his review of mortality rates in acute myocardial infarction. A few more cases occur during the winter as compared to the summer, but by and large there is little significant influence upon incidence either by occupation or time of day.[2]

The clinical symptoms of acute myocardial infarction may vary from a true asymptomatic picture to those of shock and sudden death. The prognosis of the immediate illness depends principally upon the extent and location of the infarcted area and development of complications and their seriousness.[3]

A group of authors have reported that patients with acute myocardial infarction can be divided in two general groups of good risk and poor risk patients.[4,5] This classification is of value in the individual who survives for the first few days or certainly the first two weeks. The importance of the classification lies in the fact that the good risk patient will require little active treatment.

The poor risk patient on the other hand—aside from a large myocardial infarction or lesion involving the conduction pathways—may have one or more of the following complications:

1. Persistent and intractable pain.
2. Previous myocardial infarction.
3. Persistence of shock.
4. Congestive failure.
5. Serious arrhythmias such as: auricular fibrillation or flutter, ventricular tachycardia, gallop rhythm, or conduction defects.
6. Marked obesity, diabetic acidosis, previous history of pulmonary embolism, or other states predisposing to thrombosis.[6]

The mortality rate in the first six week period after the acute myocardial infarction for the good risk patient was 3.1 per cent; it was 60 per cent for the poor risk patient.

The most valuable aid in the proper management of acute myocardial infarction is a prompt and accurate diagnosis. However, unless there are certain contraindications, it is well to treat a case as infarction until proved otherwise.

Principles of Treatment

The treatment in acute myocardial infarction may be listed as follows: 1. relief of pain; and 2. prolongation of life until healing begins by treatment of shock and/or failure, limiting the spread of the infarction, reduction of the cardiac load, prevention of thromboembolism, and prevention or treatment of serious arrhythmias.

Benjamin Boshes has pointed out that among other factors, frustration or depression influences the effect of stress on the circulatory system and that coronary flow is decreased.[7] Emotions not only affect the cortex but also the nuclei and the ancient brain that controls the viscera. Macht has demonstrated and reported that coagulation of the blood is accelerated markedly even in healthy persons by fear, apprehension, or intense worry.[8] In a recent study, 15 to 20 per cent of such patients showed a change in cholesterol phospholipid pattern of the blood.[9]

These facts emphasize a facet of therapy with which we are all familiar—that of being cheerful and reassuring. Examination of the patient should be a mixture of intelligent objectivity tempered by subjective optimism. We should give the patient the impression that the condi-

Associate Professor of Medicine, University of Illinois

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tion will heal. Prognosis, immediate and future, should be discussed with the family but not in the sickroom or in the presence of the patient.

It is poor policy to allow more than the immediate family to visit the patient for at least two to three weeks. The visitor who is anxious to relate sad cases of persons who died from the same disease should be limited to signing a guest list attached to the door of the patient's room. This alleviates the psychogenic effect of such visitors and eliminates strain on the patient.

Relief of Pain

Prompt treatment of pain with parenteral use of morphine, Dilaudid®, or Demerol® (meperidine) is essential. Meperidine is adequate for relief of pain but frequently has little effect upon easing the individual's fear and apprehension. For this reason morphine, in spite of its intolerance by many patients, is preferred in many cases. Atropine or scopalamine may be used to block the vasovagal effect of pain.

In myocardial infarction it is extremely important to individualize the dose of medication required for relieving pain. Demerol in doses of 100 mg. to 150 mg. is given intramuscularly. It may be repeated within 15 to 20 minutes in somewhat smaller amounts. I have given half the above prescribed dosage intramuscularly and the remainder intravenously immediately but slowly. Sudden relief of pain is more effective and as enduring.

Continued or recurrent pain despite adequate medication often is a sign of persistent myocardial ischemia with progressive myocardial damage. We must not lose sight of the fact, however, that pleural or pericardial irritation, rather than infarction, can cause recurrent or persistent pain. In spite of this, therapy needs to be vigorous and adequate. Persistent pain is due to a progressive infarction process and often is noted in the patient who subsequently fails to survive; so it must be considered a grave sign. In these cases, aminophyllin, 7½ grains or papaverine, 2 grains intravenously slowly, may help control pain. Especially is this indicated in cases of mild coronary shock that may become cases of severe coronary shock. Dilaudid 1/32 to 1/16 grain or morphine ¼ to ½ grain may be given slowly intravenously following dilution with 10 cc. of sterile water injected slowly into the tubing of an intravenous infusion of 5 per cent glucose in water. It should be started promptly on all patients in mild coronary shock. Delay in starting intravenous infusion, in the face of progressive coronary shock, may become more difficult because venous constriction becomes more advanced, making it difficult to find a suitable vein. When a peripheral vein cannot be found, it may become necessary to use the femoral vein. Care must be taken to give just enough narcotic to relieve pain and avoid overdosage. Excessive dosage can in itself lower blood pressure further.[10]

Coronary shock, the dreaded complication of myocardial infarction, occurs in 12 per cent of these cases.[11] There have been conflicting data concerning the hemodynamics of this condition but it is generally agreed that the cardiac output and stroke volume are low, occasionally very low. But equally low reductions in cardiac output are encountered in patients who do not exhibit shock. Therefore, in man, while myocardial insult is great there is no reliable correlation with the occurrence of shock.[12]

At the same time, oxygen is administered by nasal catheter, mask, or by tent at the rate of 6-8 L/m. This can be administered in the home initially by the local inhalator squad and enroute to the hospital. Positive pressure breathing is avoided except in cases of severe pulmonary edema since it frequently lowers blood pressure.

Vasopressor Drugs

It has been my experience, which agrees with that of others, that Levophed® (levarterenal) is the most potent of the pressor agents.[11] Eight milligrams are added to a liter of glucose infusion and the flow regulated to maintain a systolic pressure of at least 100 mm. Hg. The blood pressure is measured on an average of every 15 minutes and necessary adjustments as to rate of flow are made. Sudden rises of pressure are guarded against and may be controlled if necessary by inhalation of amyl nitrite. When the desired primary effect is attained, the rate of flow is maintained at about 1 cc. per minute or less. To minimize overloading the circulation, it is preferable to add more Levophed to the infusion rather than increase the number of drops per minute. In some cases, as much as 24 mg. has been used.[12] When protracted therapy becomes necessary, it is recommended that a cutdown be done and a polyethylene tube be inserted in the vein, to minimize leakage and a resultant

slough. If a leak occurs, the involved tissue should be infiltrated with Regitine® and the infusion stopped and started at another site or a cutdown performed. Aramine® (metaraminal) may be used with a feeling of security against a possible slough in case of leakage. It can be administered intramuscularly as well as intravenously though its effect on the blood pressure is more gradual and its duration of action more sustained after it is discontinued. It has a direct effect on the myocardium, increases coronary flow, and raises peripheral resistance.[13,14]

As soon as possible after making a diagnosis of coronary shock, insert an indwelling catheter into the bladder. The rate of urine flow in cc./ min. is then determined. This has been found to be a sensitive indicator of the degree of shock and the progress of the patient. A rise of blood pressure to 100 mm. Hg or more indicates a primary response, but unless the urine flow increases to about ½ cc./ per min. the shock state continues.[12] In general, a rise in systolic blood pressure, and a widening of pulse pressure to 20 mm. Hg or more, and an increase in urinary flow go hand in hand.

Anticoagulant Therapy

The routine use of anticoagulants is not entirely justifiable in the opinion of many clinical investigators. The question "Who should be treated with anticoagulants?" is no nearer settlement today than it was years ago. However, in my experience I have found the use of these products beneficial and it has been my practice to institute anticoagulant therapy in all my cases of acute myocardial infarction except where contraindicated. Heparin is practically nontoxic. It does not affect blood pressure, respiration, or blood chemistry, and only rare cases of hypersensitivity have been reported.[15] In the presence of an allergic history, heparin should be used with caution. Contraindications to its usage are as follows: a pre-existing tendency to bleed (hemophilia, purpura, jaundice, oozing of blood); subacute bacterial endocarditis; suspected intracranial hemorrhage; ulcerating lesion of the gastrointestinal tract; threatened abortion; and hypersensitivity to heparin.

It has been my practice to institute heparin therapy in the form of Depo-heparin Sodium N.N.R.,® 1 cc. (20,000 units) intramuscularly or subcutaneously. An effective therapeutic coagulation time of three times the normal value is maintained. At this time, it has been my practice to administer 75 mg. of warfarin sodium orally. The prothrombin time is then maintained at two to two and one-half times the normal. The contraindications to use of the coumarins as well as their substitutes parallels those of heparin, with the addition of severe hepatic disease and known vitamin K deficiency with bleeding.

The complications of this therapy do not usually occur during the acute phase of therapy of myocardial infarction so suffice it to say that hemorrhage primarily of the mucous membranes of the body, hemopericardium, myocardial rupture, or cerebral hemorrhage may occur. In any case, when bleeding is serious enough to jeopardize the patient's life, anticoagulants should be discontinued at once and counteractive measures begun. When heparin is the toxic agent, 300 to 500 cc. of fresh whole blood should be administered at once, with repeated transfusions if the situation indicates. Should dicoumarin or its substitutes be responsible for excessive bleeding and hypoprothrombinemia, successful control can be obtained in most cases with one of the forms of vitamin K. One of the most dependable has been Mephyton®. It has a rapid action and is readily available in 1 cc. ampules containing 50 mg. This amount may be repeated as often as necessary to achieve the desired effect.

Diet and Care of Bowel Functions

The diet during the first day or two of an acute myocardial infarction should be soft and easily digested. Keep the fat content low but the salt content need not be entirely restricted unless hypertension complicates the picture. Hot and iced liquids should be restricted for the proximity of the heart to the esophagus allows transmissions of sudden temperature changes which may initiate premature beats and possibly serious arrhythmia. Care of bowel function should begin immediately and not after a period of several days of constipation. The use of detergents such as dioctyl sodium sulfosuccinate may be helpful. The fact that these products are nonabsorbable and do not produce purging in effective dosages recommends them. If ineffective, mild laxatives in low dosage, or low enemas may be used in conjunction with the laxative products. It has been shown experimentally that even in poor risk patients, the use of a bedside com-

mode is safer and less taxing physically than the use of a bedpan. Benton, Brown, and Rusk demonstrated that, aside from the psychologic trauma, the use of the bedpan is an unphysiologic procedure from the standpoint of energy cost.[16]

Bed Rest and Chair Treatment

The reduction of cardiac work in the treatment of myocardial infarction remains an important part of the essential coronary care. Rest in its interpretative meaning does not necessarily mean recumbency and complete inactivity. Many good risk cases need not necessarily be confined to bed or chair for a period of longer than two weeks. Individualization of the patient continues to be of paramount importance as a facet of the whole picture in the treatment of myocardial infarction. Patients with small infarctions frequently can be managed at home, provided satisfactory and proper care is available.

Many of the poor risk cases exhibiting no evidence of shock do much better if allowed to sit in a chair alongside the bed from the onset of illness. This is a valuable aid in allaying fears and apprehensions and may also reduce cardiac work. The recumbent position lends itself, especially in the older patient, to urinary retention and collapse of renal function as well as to the development of pulmonary congestion and probable bronchopneumonia. Venous stasis, with subsequent phlebothrombosis, may ensue and pulmonary embolism may complicate the existing picture. This danger also may exist in patients who are allowed to sit in a chair. It is imperative in both instances, where venous congestion is a problem, that the condition be obviated by systematic and scheduled leg motion.

Sedation

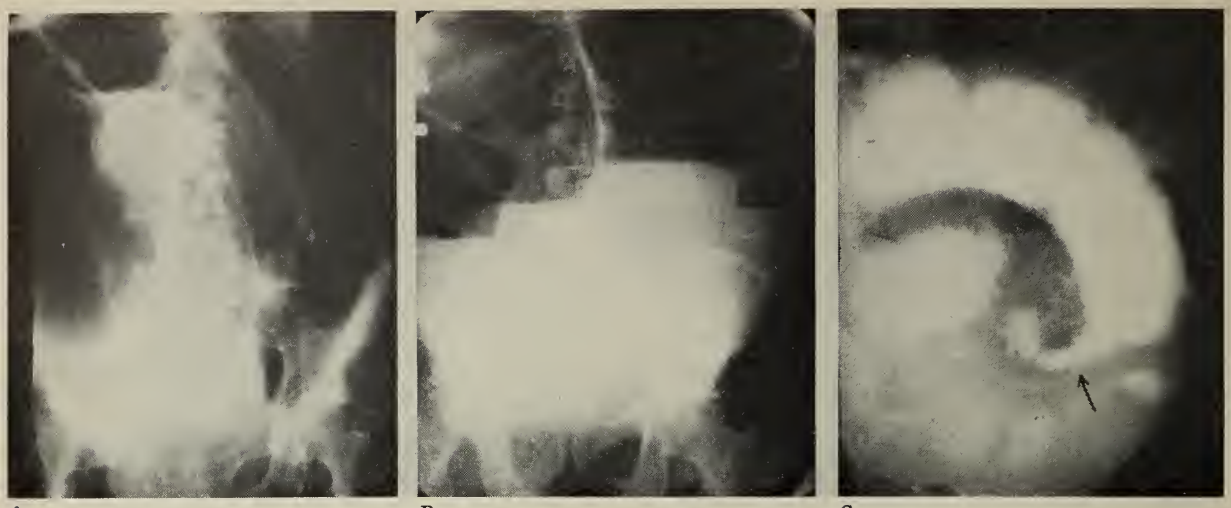
This paper will not attempt to review the complications of acute myocardial infarction which necessitate the use of such drugs as digitalis, quinidine, Pronestyl®, and diuretics. Sedation, however, can and is a useful adjunct to be used after the initial need for narcotics has passed. Sedation may range from phenobarbital to the newer tranquilizers. Some of the tranquilizers produce a fall in blood pressure and due caution should be exercised in their use. See that the patient is not oversedated, although mild drowsiness and relaxation should be maintained during the first week. Bromides may be helpful, especially in older patients and those who do poorly on barbiturates. Chloral hydrate has been used also with good success for nocturnal sedation.

Summary

1. A review of the current concepts of therapy of acute myocardial infarction is presented with comments of personal experience.
2. The objectives of medical therapy are the relief of symptoms by pharmacological, physical, and psychotherapeutic means. A valid approach to this problem is presented.
3. Management of coronary shock with the use of various drugs has reduced mortality in this situation from 80 per cent to 60 per cent, according to the current literature.
4. Anticoagulants, their indications and contraindications, are discussed briefly.
5. Diet, bed rest, chair treatment, care of the bowel, and sedation in acute myocardial infarction are presented.

REFERENCES

1. Master, A. M., and Jaffe, H. L.: Factors in the Onset of Coronary Occlusion and Coronary Insufficiency, J. A. M. A. **148**:794, 1952.
2. Schnur, S.: Mortality rates in Acute Myocardial Infarction: IV. The Seasonal Variation in Morbidity and Mortality, Ann. Int. Med. **44**:476, 1956.
3. Ernstine, A. C.: Complications and Sequelae of Acute Myocardial Infarction, J. A. M. A. **150**:1069, 1953.
4. Russek, H. I.; Zohman, B. L.; Dolmer, A. A.; Russek, A. S.; and White, L. G.: Age and Survival in Cases of Acute Myocardial Infarction, J. A. M. A. **147**:1731, 1951.
5. Schnur, S.: Mortality Rates in Acute Myocardial Infarction, Ann. Int. Med. **39**:1014, 1953.
6. Russek, H. I., and Zohman, B. D.: Selective Versus Routine use of Anticoagulants in Acute Myocardial Infarction, J. A. M. A. **156**:12, 1954.
7. Boshes, B.: Emotions, Hypothalamus, and the Cardiovascular System, Am. J. Card. **1**:212, 1958.
8. Macht, D. L.: Influence of Some Drugs and of Emotions on Blood Coagulation, J. A. M. A. **148**:265, 1952.
9. Kitchell, J. R.: General Considerations in Treatment of Myocardial Infarction, Am. J. Card. **1**:224, 1958.
10. Altschule, M. D.: Hazards in the Treatment of Cardiac Decompensation, New England J. Med. **248**:493, 1953.
11. Binder, M. J.; Ryan, J. A.; Marcus, S.; Mugler, F.; Strange, S.; and Agress, C. M.: Evaluation of Therapy in Shock Following Acute Myocardial Infarction, Am. J. Med. **18**:4, 1955.
12. Agress, C. M.: Management of Coronary Shock, Am. J. Card. **1**:231, 1958.
13. Sarnoff, S. J.; Case, R. B.; Berglund, E.; and Sarnoff, L. C.: Ventricular Function; Circulatory Effects of Aramine; Mechanism of Action of Vasopressor Drugs in Cardiogenic Shock, Circulation **10**:84, 1954.
14. Weil, M. H.: Clinical Studies on Vasopressor Agent: Metaraminal, Am. J. M. Sc. **230**:4, 1955.
15. Goodman, L., and Gilman, A.: The Pharmocological Basis of Therapeutics. New York, Macmillan, 1956.
16. Benton, J. G.; Brown, H.; and Rusk, H. A.: Energy Expended by Patients on the Bedpan and Bedside Commode. J. A. M. A. **144**:1443, 1950.



A B C

Figure 1. Radiographic examination of the abdomen in a patient with sigmoid volvulus. A: supine film shows a largely distended double loop of bowel oriented toward the pelvic region. B: multiple fluid levels are seen in the upright film. C: the site of torsion is in the barium enema study shown (arrow).

Diagnostic Value of Radiography In Volvulus of the Colon

ENRIQUE SCHWARZ, M.D.,* *Chicago*

Radiographic examination of the abdomen and colon is of vital importance for preoperative diagnosis of volvulus of the colon. This condition does not occur frequently. It is more common at the sigmoid level than at the cecum or junction with the small bowel.

If the diagnosis is not made early, mortality increases considerably. Therefore, the assistance of the radiologist offers a major clew to success in the management of this condition. Although some authors do not recommend barium enema examination as a routine in these patients,[4,7] I feel that the procedure is the only one that offers to the clinician confirmatory evidence of the presence of volvulus. The clinical findings in these cases are too vague and insufficient as a rule to reach a diagnosis.

The commoner symptoms occurring in these patients are those of intestinal obstruction such as nausea, vomiting, abdominal pain, and obstipation. Physical examination reveals abdominal tenderness and distention. A palpable tumor mass is present occasionally,[1] but there is no sign or symptom that could offer a clew as to the cause of the obstruction. This obstruction can be complete or incomplete and present itself as an acute, chronic, or intermittent picture. There are several reports of patients who were relieved by conservative measures or after the administration of the barium enema.[2] However, in most instances a surgical procedure, such as cecostomy and/or resection, is necessary to carry out decompression and relieve the torsion of the colon,

Assistant Professor of Radiology, College of Medicine, University of Illinois, Chicago,

which at times reaches 720 degrees[5] with the accompanying changes in the blood supply to the intestine. Hemorrhage, perforation, and peritonitis with fatal consequences may follow these changes.

Roentgen findings

The radiographic survey of the abdomen in patients with volvulus of the colon shows a hugely dilated loop of bowel with loss of the normal markings. Fluid levels can be seen in upright films, and they adopt various patterns depending upon the location of the volvulus. When torsion is at the level of the sigmoid, a double loop can be seen occupying the entire abdomen, oriented toward the pelvis and displacing the stomach, diaphragm, and other nondistended portions of the colon (Figure 1A). In the film taken with the patient upright, several fluid levels can be seen (Figure 1B). Barium enema films sometimes show the site of torsion as a spiral or as a bird's beak pattern, proximal to the dilated rectum (Figure 1C).

Volvulus of the transverse colon is rare.[3] Only four cases have ben reported at the splenic flexure.[6] In patients with cecal volvulus, the cecum leaves the right lower quadrant of the abdomen and appears as a single, oval, distended segment of bowel, lacking haustrations, and showing fluid levels in the upright film. The barium enema may show the site of torsion (Figures 2 A, B, C).

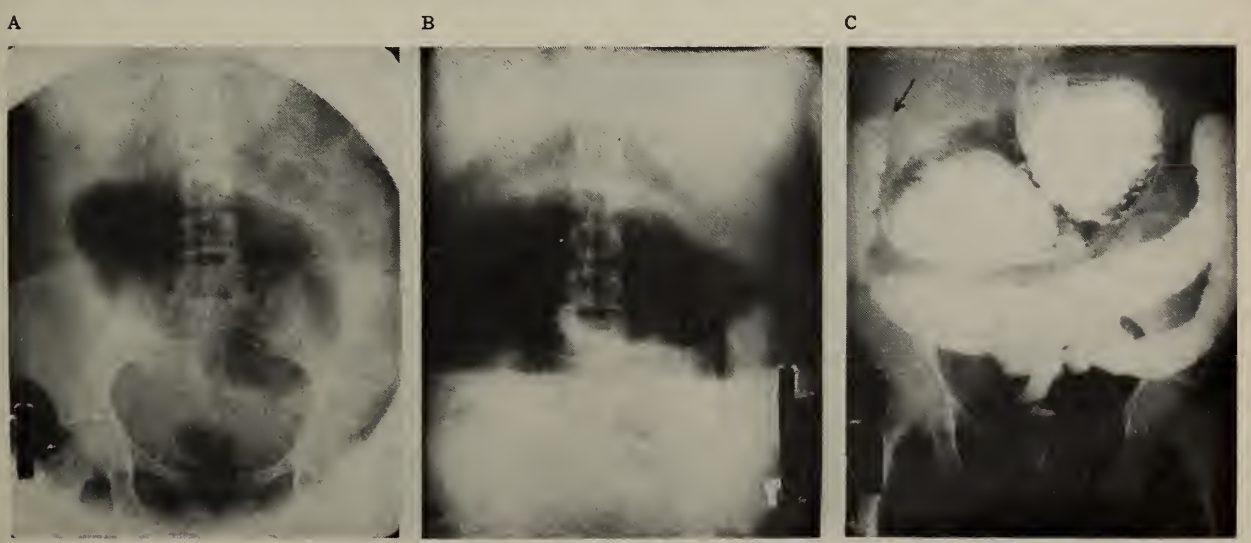
Summary

Radiographic examination of the abdomen is mandatory in cases of intestinal obstruction, bearing in mind that intestinal volvulus, although uncommon, may be causing the obstruction. If a huge, distended segment of large bowel with fluid levels is discovered in the plain film of the abdomen, a barium enema examination is indicated. It is possible to demonstrate by this method valuable signs that help make the diagnosis of volvulus of the colon; and, in most instances, the site of torsion can be discovered. This is particularly important in cases of acute abdomen where the mortality may be high if early diagnosis of volvulus is not established.

References

1. Abrams, H. L., and Wass, W. A.: The Diagnosis of Volvulus of the Cecum, Radiology **60**:36-45, 1953.
2. Anderson, D. H.: Volvulus in Western India, Brit. J. Surg. **44**:132-143, 1956.
3. Ballarati, V., and Chiariotti, F.: Il Volvolo del Colon Transverso, Radiol. med. Tor. **45**:122-131, 1959.
4. Byrne, J. J.; Swift, C. C., and Farrell, G. E.: Volvulus of the Cecum, Arch. Surg. **164**:378-383, 1952.
5. Dean, D. L.: Volvulus of the Cecum, Ann. Surg. **136**:-319-325, 1952.
6. Poppel, M. H.; Zeitel, B. E., and Abrams, R. M.: Volvulus of the Splenic Flexure, Am. J. Digest. Dis. NS1:-380-386, 1956.
7. Wangensteen, O. H.: Intestinal Obstructions. 3rd ed. Springfield, Ill., Charles C. Thomas, 1955. PP: 659-688.

Figure 2. Typical radiologic findings in a case of cecal volvulus. A: the hugely distended and ectopic cecum is seen in the supine film. B: fluid levels are seen in the upright film. C: the barium enema reveals the site of torsion (arrow). The cecum is seen located high in the midabdomen.



Anesthesia for the Geriatric Urological Patient

P. W. Searles, M.D.* and D. G. Seymour, M.D.**, *Chicago*

The anatomic and physiologic changes occurring in the geriatric patient are so numerous and well known it is sufficient to remind ourselves that there is atrophy of all organs except the prostate and the heart. In urological surgery, several other factors must be considered. Many procedures require the use of cautery so that the choice of agents narrows; frequently there is considerable blood loss in areas where control is difficult. The use of abnormal body positions—such as the Trendelenberg, lithotomy, and lateral positions with the kidney rest elevated—are strains even on healthy individuals. The vital capacity is reduced remarkably. Imposing these positions on elderly, diseased patients is the worst feature of urological anesthesia.

Despite these difficulties, the morbidity and mortality in geriatric urological anesthesia is remarkably low regardless of whether local, spinal, or general anesthesia is employed. There are valid objections to and reasons for each agent and technique, but the important consideration is that the method selected should enable the anesthesiologist to maintain as near normal physiology as possible.

Many reports appear in the literature of anesthesiology and urology praising one method while ignoring or condemning others. The results are not too different, but the groups report that their technique of the last 10 years is superior to the method used in previous decades. However, this improvement might be due to other factors, such as better diagnostic procedures and preparation of the patient, more accurate blood replacement, control of infections, anti-uremic measures, the development of steroids, and more well qualified anesthesiologists. In this country, the anesthesiologists come from varied backgrounds. They must be allowed the full use of their background in teaching and practical experience. They must have sufficient experience with and confidence in the agent and technique selected as well as confidence that the job can be done safely.

There are peculiarities or relative limitations to each technique and agents. For example:

1. Local or topical anesthesia assumes a large role in urology because many cystoscopies and circumcisions can be performed with nothing else. Cases of gross cystitis are unsuitable for local analgesia, as distention of the bladder with irrigating solutions causes painful spasm. Bleeding or traumatized urethras are unsuitable because of the rapid vascular absorption of the drug. For more formidable procedures, local anesthesia can be inadequate and dangerous. A cardiac patient who feels pain and develops mental strain is a candidate for coronary occlusion.

2. Spinal anesthesia, particularly the low spinal or saddle block, is a companion of urological surgery historically and is considered the technique of choice by many. Most surgeons are familiar with its good features. However, there are times when it is contraindicated and other times when it imposes a strain on body physiology. Spinal anesthesia is contraindicated in any form of central nervous system disease; and relatively contraindicated in unwilling or uncooperative patients; and unwise in patients with dyspnea, hypotension, bleeding, congestive heart failure, distention, perforation, or marked obesity.

Spinal anesthesia is useful in cystoscopies and transurethral procedures. The sensory nerve supply to the bladder and prostate has origins as high as T-10. The skin areas are supplied by

*Clinical Professor of Anesthesiology, University of Illinois College of Medicine.

**Clinical Associate in Anesthesiology, University of Illinois College of Medicine.

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T-8 to T-12 except for the genitalia which have sacral origins and branches from the ilioinguinal and lumboinguinal nerves.

The somatic nerve supply through the pudendal nerve arises in S-3 and S-4 and proceeds to the external sphincter and urethra and genitalia. The parasympathetic supply arises in S-2 and S-3 and goes to the mucous membrane of the bladder and the rest of the sphincter. Sensory impulses travel through the somatic and parasympathetic tracks. The sympathetic fibers carry sensory impulses from the bladder to the spinal cord, normally to S-1 through S-4, but when the bladder is overdistended, reach as high as T-11. The kidney and ureter are supplied by T-10, 11, and 12. The prostate gland has a varied supply from T-10, 11, and 12 and S-1, 2, and 3.

Balanced anesthesia

General anesthesia can be used in every situation in geriatric urology except in the presence of imminent or evident uremic coma. So-called light or balanced anesthesia is the technique most widely used by trained anesthesiologists today. It is simple in concept, easy to administer, and safe for the majority of patients. Two or more agents are used together in small and safe quantities rather than administering a single agent in a toxic dose.

An ultra short-acting barbiturate such as Pentothal Sodium® is administered by intravenous drip to produce hypnosis, the speed of injection being made compatible with the age and condition of the patient. The usual dose required for this state in the geriatric patient will seldom exceed 100 mg. Giving 100 mg. to a 70 year old man will have the same effect as 500 mg. in a 25 year old man. A controlled drip of a 0.5 per cent solution enables the anesthesiologist to discontinue the administration of Pentothal just as the lid reflex is abolished. No more is used throughout the procedure. This technique removes the objection some people have to the administration of Pentothal to geriatric patients because they fear repeated injections will lead to an overdose. In this belief they are correct.

Following this first and only controlled Pentothal injection, oxygen and a gaseous agent are administered by mask or through an endotracheal tube. Some positive pressure is required initially. Any state of muscular relaxation can be obtained by the use of an intermittent infusion of succinylcholine by intravenous drip.

The necessity for endotracheal intubation is dictated by the degree of difficulty in establishing and maintaining an adequate and clear airway. The decision is left primarily to the anesthesiologist. Peculiarities of the tongue, mandible, epiglottis, or other neck structures may require intubation for safety's sake in even the simplest surgical procedures.

Nitrous oxide is the safest and most innocuous of all inhalation agents when administered with sufficient oxygen, and it has the advantage of being nonexplosive. However, since, with adequate oxygen, nitrous oxide is an impotent agent, its use must be supplemented by intravenous agents such as Demerol® or succinylcholine. This is a minor burden for the anesthesiologist, and the effects of the gas and supplementary agents can be made momentary.

In the Presbyterian-St. Luke's Hospital of Chicago, when general anesthesia is used for the geriatric urological patient, a small dose of Pentothal is given, followed by nitrous oxide and oxygen, given with assisted or controlled respirations. Relaxation and control of side effects, such as laryngospasm and coughing, are controlled by succinylcholine drip. The majority of these patients are awake and alert on the operating table immediately following surgery. Hypotension is a rare complication when the Pentothal dose is kept minimal and is treated quickly with a vasopressor.

There are occasions when nitrous oxide is not used. Ether is valuable in the asthmatic patient. Cyclopropane® is particularly indicated for induction if the patient is in shock. Trichlorethylene can be administered for the relief of pain without loss of consciousness, and is very useful in simple urological procedures, such as the removal of suprapubic packing and painful irrigations. Fluothane®, though a relatively new agent, is both potent and nonexplosive and will find increasing usage in the more formidable and lengthy procedures.

The physical and mental status of the patient, the requirements of surgery, and the training of the surgeon and the anesthesiologist will all influence the choice of techniques and agents used in urological surgery. A wide choice is available. Frequently, custom and habit dictate the final choice if all other factors are equal.

Some Obstetrical Emergencies

Willard C. Scrivner, M.D.*, *East St. Louis*

In the experience of any one doing obstetrics, even if only for a brief period of his medical career, there are cases and problems that merit the label obstetrical emergencies. These situations may remain simple and be so resolved or run the gamut to and including a fatal outcome for the patient involved. Humbly and unselfishly, every conscientious physician and his team of disciplines strive to avoid a monopoly of these unhappy situations. Not only is he motivated by concern for womankind and resultant statistical reflections, but also by desire for personal tranquillity.

Training, experience, and judgment may meet their full challenge in any of these emergencies. While there is nothing unique in the following experiences, they are worthy of review for they represent two of the largest groups of problems contributing to maternity morbidity and mortality. These abbreviated resumes combine information from office and hospital records.

Case report: T. D. A., 33 year old, white female, gravida V, para II, miscarriage II. First visited office on 4-14-58 with an obstetrical history of spontaneous labor and delivery in 1948 of a living child. In 1952 spontaneous delivery of child who died shortly after birth. In 1957 spontaneous labor and delivery of a normal child who is living and well. Patient is Rh negative and her husband is Rh negative. Kahn was negative. Last menstrual period was 1-28-58. On her first visit she weighed 139, B.P. 140/80. General physical examination otherwise within normal limits. She had received her third polio injection. Subsequent visits and data recorded are herein listed. 4-30-58 Weight-140, B.P. 138/84, urine negative, McDonald 9 cm., medications of C.V.P., Ferronod, Norlutin. 5-24-58 Weight-142, B.P. 125/70, McDonald 12 cm., urine negative, medications plus liver injections, hemoglobin 68%, RBC-3,812,500. 6-14-58 Weight-146, B.P. 118/80, McDonald 16 cm., urine negative, Diuril 250 mgs., every second day, put on rest. 7-2-58 Weight-148, B.P. 150/72, McDonald 21 cm., fetal heart tones o.k., diet, decreased salt intake, Diuril 50 mg. and two Biphetamin® Spansules 7.5 mg. every second day alternating with Diuril. 7-23-58 Weight-151, B.P. 130/70, McDonald 23 cm., fetal heart tones at RLQ, emphasis on above and cautioned. 8-16-58 Weight-154, B.P. 120/70, McDonald 26 cm.-F.H.T.-RLQ, same medication plus liver. 8-27-58 Liver injection. 9-12-58 Weight-158, B.P. 150/80, McDonald 27 cm., F.H.T. LLQ. Diuril every 3 days, partial bed rest and cautioned. 10-3-58 Weight-163, B.P. 140/80, McDonald 30 cm., fetal heart tones LLQ. We conferred with her husband about his wife's condition and warned him of potential complications. 10-16-58 Weight-163, B.P. 160/90, trace of albumin, McDonald 32 cm., cervix closed, fetal heart tones, LLQ. She was placed on complete bed rest with detailed instructions.

On 10-18-58 she telephoned complaining of nausea, vomiting, and diarrhea. She thought she had intestinal flu and requested medicine be sent to her. However, she accepted our advice to come to the office immediately where we found B.P. was 140/60, Temp. 99°, and some pitting edema of the lower extremities. She was sent to the hospital immediately.

Approximately 1½ hours later, in hospital, the following laboratory information was obtained. 4 plus albumin, NPN-39, uric acid 4, cholesterol 245, sugar 74, hemoglobin 60%. Approximately 15 minutes later, her B.P. had risen to 258/140 and she was seized with her first eclamptic convulsion. Medications consisted of magnesium sulfate 25%, 10 cc. I.M. after the first convulsion and 5 c.c. after each additional three convulsions, Unitensin® .5 cc. I.M. (3 doses), oxygen inhalator, 1000 cc. glucose in

*Assistant Clinical Professor, Department Gynecology and Obstetrics, Washington University, St. Louis, Mo.

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water. Membranes ruptured artificially with 2 fingers' dilatation; irritable uterus. Delivered in bed, with outlet forceps, of small living infant. There was approximately 150 cc. blood loss accompanying delivery. Patient was not moved from labor room to delivery room.

This event took place on a Saturday afternoon. There were no special nurses available so husband was permitted and invited to be with his wife during this alarming episode. Following delivery there were 13 successive convulsions. Treatment consisted of 500 cc. 10% glucose in water, 500 cc. 20% glucose in water, and 20 cc. 50% glucose intravenously, magnesium sulfate, and one injection of Serpasil® .2 mgs. B.P. finally settled to 160/105. Continued improvement ensued, the urine cleared, and the E.K.G. was normal after last convulsion.

Patient had a residual haziness about the entire toxic episode, stating she barely recalled going to the hospital and remembered nothing after she had been put to bed. Her husband was in constant attendance and witnessed our care of this critically ill patient. Without solicitation, he volunteered that whenever possible he was going to inform his friends and fellow workers of the advisability and necessity in having their wives cooperate completely with their physicians when they became pregnant. It is fortunate this patient telephoned for what seemed to be a minor illness and was in reality a serious complication. At the end of her postpartum follow-up, she was dismissed in January, 1959 to an internist for hypertension [160/90].

Case No. 2: While in early morning surgery on 11-7-58, Mrs. M. C., 27 year old, white female, had the following message relayed to me: Her last menstrual period was 9-10-58. This a.m. she developed cramps and gas and didn't feel well. She was advised to enter hospital. Examination revealed B.P. 80/60, pulse 110, and pallor. She complained of tenderness in the lower abdomen only. Pelvic exam revealed the uterus slightly enlarged and tender right adnexa. On cul de sac puncture, 150 cc. of bright blood obtained. Patient put in knee chest position for a few moments but no shoulder pain developed. She was taken to surgery under 1% Procaine® local anesthetic and given oxygen, I.V. fluids, and blood. Abdomen opened; found to be filled with blood. The right tube had ruptured with pregnancy at the junction of its inner third. Tube was ligated to control hemorrhage. Left adnexa normal. Appendix surgically absent. Abdomen completely explored and closed. Postoperative course was satisfactory and she was dismissed on the eighth hospital day. The interesting features of this case are: no shoulder pain as might be expected with an abdomen filled with blood, a positive cul de sac tap, and absence of the defection desire so often present in an ectopic pregnancy.

Case report No. 3: Mrs. D. L., 34 years old, white female, gravida VI, para V. She visited office for medical care on 12-29-58. In her O.B. history, she had been delivered vaginally 12 years ago. A subsequent pregnancy was terminated by cesarean section, prolapsed foot; then another delivery vaginally, accompanied by hard labor. A repeat cesarean section and another. The patient was somewhat vague about the deliveries in her past history. She did reveal receiving transfusions during her last postpartum course. She had a clean appendectomy in 1947. Menstrual history: onset at 14 yrs., every 28 to 35 days, duration 5 days with cramping. Last menstrual period 5-11-58 with E.D.C. to 2-18-59. At the time of her visit, 12-29-58, normal measurements, weight 141, B.P. 130/80, Rh positive, hemoglobin 63%. She was placed on Ferronod, restricted diet, and adequate rest. Patient declined polio injections. She returned 1-29-59, one month later, stating she failed to return sooner because of sick children. Weight 145, B.P. 136/84, F.H.T. o.k. Given Inferom® 2 cc. diet, again cautioned and general measures. 2-4-59 Weight-142, B.P. 120/80, McDonald 32 cm. F.H. beat-RLQ. o.k. It was agreed to arrange for a complete hysterectomy one week hence. At 3:00 p.m. of the same day, patient experienced sudden pain, returned to office per ambulance on way to hospital. Fetal heart beat very slow, irregular, 80 beats per minute, B.P. 110/70, beads of perspiration noted on her forehead. Upper third of old abdominal scar very tender.

Hospital course: Abdomen prepared, retention catheter inserted, and blood drawn for cross-match. 1% Procaine infiltration; abdomen opened and small amount of bright blood was present. She had a 3 cm. rupture in upper end

of old uterine scar. It was necessary to insert only two fingers and the old scar separated its entire length. A small living child was delivered and the baby needed some resuscitation efforts before being released to a pediatrician for his services. The diseased uterus was removd by complete abdominal hysterectomy adnexo preservation. The patient made a satisfactory recovery and was sent home on ninth postoperative day.

Conclusions

1. These cases reveal clearly that serious emergencies may strike with great speed in spite of what may be considered available, adequate prenatal care.

2. While experience in managing these problems is essential, it is necessary to be alert constantly and realize these problems do arise.

3. Anticipation and a clear-cut plan of proposed action for these and other obstetrical emergencies are a must from the time we assume medical responsibility until the patient has recovered completely.

4. These cases were selected for presentation because they exemplify the problems encountered in any active gynecological and obstetrical practice. They are important clinically since statistically their unfavorable outcome accounts for major causes of maternal mortality. They serve to emphasize the advisability of alerting patients to latent complications in their respective cases and the necessity for a close patient-doctor relationship in medical practice. It is prudent for all of us to remember that the next time the telephone rings it may be a real emergency such as one of the cases presented.

An old educational problem

The trend in undergraduate teaching has de-emphasized the surgical specialties to the point where the student may actually have only six hours of lectures to cover the extensive field of otolaryngology. In the winter months the patient load of the general practitioner and the pediatrician may be as high as 50 per cent for upper respiratory complaints. They must rely on the erroneous impression that a working knowledge of antibiotic therapy eliminates the necessity for special training in this field. The present day teaching in some institutions discourages or even forbids myringotomy in acute otitis media since there is no opportunity to associate an irreversible conductive deafness with past history of ear infections. The vocabulary has been reduced to the point where the word "sinus" covers all ailments of the nose and "fungus," all sore ears. Of equal importance, the otologist continues to pick up the perceptive deafness due to the indiscriminate use of ototoxic drugs such as streptomycin, dihydrostreptomycin, kanamycin, and neomycin. It is evident then that more time must be allotted to undergraduate as well as postgraduate teaching.

The predictable effect of the prophescies of doom was the swing of the pendulum to the extreme negative side for the younger men entering the specialty, but the swing back has been noticeable for the past two years. Trainees are not motivated by prospects of a life of ease but by the desire to occupy an important niche in the practice of medicine. The demand for otolaryngologists in all parts of the country far exceeds the supply. The young man may hang his shingle almost anywhere and soon have more work than his time permits. *Claude D. Winborn, M.D. Rebirth of a Specialty. Texas J. Med. Dec. 1959.*

The most dangerous day

We often speak of the first day of a person's life as being the most dangerous time of his existence. This is exemplified by the fact that the total mortality for the first day of life was 35.8 per cent, while the mortality for the next 29 days was 33.7 per cent, and for the next 11 months was 30.5 per cent. *Heyworth N. Sanford, M.D. Perinatal Mortality. Wisconsin M. J. Dec. 1959.*

Formula Diets and Weight Reduction

Alvan R. Feinstein, M.D.*, *Irvington-on-Hudson, N.Y.*

Any program that helps the obese patient safely obtain or remain on the negative caloric balance necessary for weight reduction is welcome. A formula diet constitutes one form of therapy.

In any weight reduction program the patient must try to increase energy output, decrease energy intake, or both. Attempts to raise the output of energy by physical or pharmaceutical methods have seldom resulted in sustained weight loss. Physical exercise may be vigorous and seem prodigious to the patient, but its increment of caloric expenditure adds only a small fraction to the larger amount usually consumed for basal needs and by ordinary activities. Exercise may improve muscle tone, help coordination, and create a sense of well-being in some patients. It may be useful in preventing weight gain, as long as the exercise is done continually and is not followed by increased food intake. However, as long as man must walk 36 miles to lose one pound, exercise will remain an inefficient method for weight reduction. Pharmaceutical attempts to raise the body metabolic rate have not been successful because the drugs were either (1) ineffective (e.g., pituitary hormone preparations), (2) damaging to body tissues (e.g., dinitrophenol) or (3) unable to overcome homeostatic regulation, so that they could be active only when given in dangerously toxic dosage (e.g., thyroid).

Since energy output cannot be raised effectively, reduction of intake becomes the primary approach to weight reduction. Intake of energy can be reduced by numerous methods, all of which involve the restriction of calories by the selection, regulation, or elimination of certain natural foods in the diet. To help promote adherence to the dietary restrictions, a number of adjuncts have been used. These involve (1) environmental control, (2) appetite depressants, (3) mood alteration and (4) homeostatic manipulation.

Control of the patient's environment by such means as hospitalization or milk farms is almost always successful, but it obviously has limited application.

Use of appetite depressants or procedures or drugs which alter the patient's mood or psyche has often been followed by good results. In most situations, however, the patient does well at first but later finds that the adjunct has "lost" its effect. Homeostatic manipulation, as described above, is unsuccessful when done by hormones in physiologic doses, and when done by diuretics to produce transient losses of water does not affect energy balance.

Despite the many available diets and dietary adjuncts, the results of weight reduction programs are poor.[1,2] Losses of over 40 pounds generally occur in less than 2 per cent of those who begin to diet; losses of over 20 pounds are rare in more than 15 per cent of patients; and of those who manage to achieve significant weight losses, only 1 to 2 per cent maintain the loss for 5 years. These results indicate that many diets have been "ideal" for the nutritionists who designed them but regularly have been abandoned by the patients who had to live with them.

Factors in weight reduction

A recent critical analysis[2] of the treatment of obesity reached the following conclusions: The ability to maintain voluntary caloric deprivation is influenced by (1) the patient's life situation, (2) the patient-physician therapeutic relationship, and (3) the diet and dietary adjuncts. Each of these factors contributes in different ways and with different force to the performance of each patient; success is impossible if any of the three is sufficiently negative. In most instances, the patient himself and the therapeutic

*Assistant Professor of Medicine, New York University College of Medicine; Clinical Director, Irvington House, Irvington-on-Hudson, N. Y.

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the authors and do not necessarily represent the official view of that committee.

relationship are the really significant factors because they determine whether the dietary program will be maintained. Specific contents of the diet and its adjuncts are of relatively minor importance, although *post hoc* reasoning has often given them sole credit for dietary successes.

The problem seems to be that, for a variety of reasons, many overweight patients receive comfort, sedation, and pleasure from food, and they develop the discomforts of anxiety and tension when deprived of it. Their ability to tolerate this discomfort is somewhat affected by the medication and dietary adjuncts, but it is more strongly influenced by their motivation, psychic status, and support from the physician-therapist.

The role of the physician as a therapeutic agent is often not considered in many analyses of dietary success, but it frequently may be a decisive feature. Many physicians fail to perform this role because they may be disinterested, or because they find it too difficult or time-consuming to learn, prescribe, and check the many complexities of intake and caloric measurements in standard food diets. To provide motivation for obese patients who have repeatedly failed to achieve success with standard diets, a new and radical approach may be desirable merely because of its novelty. An approach which eliminates food entirely may be effective, as well as novel, because certain patients may prefer to avoid foods completely rather than to reduce their intake.

For these reasons, formula diets are a helpful addition to the therapeutic armamentarium in obesity. Like most "new" treatments, they were first used almost a century ago. Karell, in 1866, and later Moritz, in 1908, completely replaced foods by milk or buttermilk as the sole nutriment for obese patients. The formula mixtures of recent years were developed primarily as a convenient technique for performing metabolic studies in hospitalized patients.[3] Formula feeding is ideal for this purpose because constituents can be assigned, measured, varied, distributed, and analyzed with a precision impossible with ordinary foods. Studies of lipid metabolism demonstrated that formulas could be accepted and tolerated by hospitalized patients. Formula diets were applied then to metabolic studies of hospitalized obese patients, who were maintained on formulas exclusively for over a year. The patients lost weight well, remained in good health, and spontaneously commented that they found the diet as pleasant, and, in some instances, more acceptable than many of their previous programs.

Effectiveness

These results led to testing formula diets in treatment of 106 out-patients,[4] who were examined at weekly or bi-weekly intervals in a special clinic. For home use, a 900-calorie mixture of evaporated milk, corn oil, dextrose, and water was the most palatable and simple hospital formula. It was prepared daily by the patient and taken in four to six feedings. Water, coffee, tea, carbonated water, low-calorie commercial beverages, and bouillon soup were permitted ad libitum. Multivitamin preparations were the only medication.

Some patients maintained the formula diet for long periods of time with complete fidelity; others used it as a basic dietary staple, with regular episodes of food supplementation; others quickly abandoned the program. The over-all results were spectacular: 59 per cent of the starting patients lost at least 20 pounds and 31 per cent lost 40 pounds or more. No patient developed any evidence of nutritional deficiency during or after the dieting period.

While the therapeutic effect of an interested physician and a special clinic may have made important contributions to the success of this diet, its intrinsic simplicity and inflexibility were major advantages to the patient and physician:

(1) For the patient, there were no questions or decisions on choice of foods and hence no possibility of self-deception.

(2) For the physician, the formula diet could be prescribed without using complicated food tables, and the adherence given to it could be easily checked since the patient was usually aware of the nature and quantity of each dietary departure. With a minimum of time required for discussing the nebulous aspects of food intake, the physician could devote more attention to the patient himself.

The major disadvantage of a formula diet is monotony, which makes formulas unappealing to most non-obese individuals or to those whose only motivation is cosmetic. It is often judged differently, however, by patients who are tremendously obese, desperate about their many previous failures, and anxious to try a new form

of therapy which can assure them of sustained weight loss as long as the prescription is faithfully maintained.

The safety of the particular formula diet used in the above studies had been questioned[5] because it provides only 22 Gm. of protein per day. The nutritional tradition of high-protein intake *during caloric restriction* has little or no scientific data to support it. Concepts of nitrogen-balance requirements were established in patients of normal weight on maintenance diets; there is no proof that these concepts are valid when extrapolated to obese patients on reduction diets. Diseases associated with low-protein intake have occurred only when the total caloric intake was high, not under caloric restriction. The potential evils of transient negative nitrogen balance during weight reduction frequently are described, but they have never been demonstrated clinically. In studies of the malnutrition of wartime starvation, effects of vitamin depletion and infectious disease have not been adequately separated from those attributed to protein and caloric insufficiency. In addition to these theoretical features, studies of nitrogen balance during prolonged periods of weight reduction[6] show the same results for both high-and low-protein diets, viz., patients initially have a moderate or marked negative nitrogen balance which later becomes only slightly negative or reaches equilibrium. Thus, the objections to the low-protein content of one formula diet cannot be sustained on scientific grounds and are contradicted by intensive clinical evidence of its safety.[4]

Conclusions

The utility of a formula diet in weight reduction does not depend on its form or contents. A liquid mixture probably is prepared more easily than a solid one; a palatable mixture is more appetizing than one that is not. Aside from these requirements, a formula can be made in any desired arrangement. Its protein, fat, or carbohydrate constituents may be large or small; its salt, mineral, and vitamin contents can be altered to specific goals. The important features are that the mixture be calorically-restricted and invariant, that it replace ordinary foods, and that it be palatable, portable, and convenient for the patient and the physician.

A formula diet is probably best reserved for patients who are markedly overweight, who have had repeated failures with standard dietary approaches, and who are willing to attempt drastic measures. But it can also be used for short-term reduction periods in less obese individuals. Since the physician's enthusiasm is an integral part of the therapy, it should not be used unless he is convinced of its safety and effectiveness. It is obviously no answer to the problems of obesity; it merely presents an alternate form of treatment. The diet is difficult, unappealing to many patients, and must be followed by readjustment to conventional foods. Its excellent results in a carefully-tested series of patients show that it is safe, efficient, inexpensive, and practical. In a disease whose therapeutic results are so notoriously bad, the salvage of only a single patient may be considered a triumph. Any diet which can perform this salvage safely and with appreciable frequency is a worthwhile therapeutic addition, even if it does not conform to nutritional concepts which lack scientific or clinical proof and which are supported only by the dogmatic weight of tradition.

REFERENCES

1. Stunkard, A., and McLaren-Hume, M.: The Results of Treatment for Obesity, Arch. Int. Med. 103:79-85 (Jan.), 1959.
2. Feinstein, A. R.: The Treatment of Obesity: An Analysis of Methods, Results and Factors Which Influence Success, J. Chron. Dis. 11:349-393 (April) 1960.
3. Ahrens, E. H., Jr., Dole, V. P., and Blankenhorn, D. H.: The Use of Orally-Fed Liquid Formulas in Metabolic Studies, Am. J. Clin. Nutrition 2:336-342 (Sept.-Oct.), 1954.
4. Feinstein, A. R., Dole, V. P., and Schwartz, I. L.: The Use of a Formula Diet for Weight Reduction of Obese Out-Patients, Ann Int. Med. 48:330-343 (Feb.), 1958.
5. Jolliffe, N.: Low-Protein Diets for Reducing, J.A.M.A. 161:1633-1636 (Aug. 25), 1956.
6. Feinstein, A. R., and Schwartz, I. L.: Nitrogen Balance in Obese Patients After Prolonged Weight Reduction on Low-Calorie, Low-Protein Formula Diets, Clin. Res. Proc. 5:180 (Apr.), 1957.

Medical Management of Uveitis

Lawrence J. Lawson, Jr., M.D., *Chicago*

ENDOGENOUS uveitis is an ophthalmological manifestation of disease processes originating systemically. The successful management of these cases requires the close cooperation of the family physician and the ophthalmologist.

Uveitis may present itself as iritis, iridocyclitis, or chorioretinitis, but the site of involvement does not incriminate any specific etiological agent. Progress has occurred in the treatment of patients with this disease because of improved diagnostic techniques, newer drugs, and more knowledge about its etiology.

The relative importance of specific diseases is changing:[1]

	1941	1944	1953
TB	79	52	23
Syphilis	16	17	7
Sarcoid	1	10	6
Brucella	1	10	7
Toxoplasmosis	0	0	26
Virus	3	5	13

The general decrease in the incidence of syphilis, the more accurate diagnosis of other diseases simulating tuberculosis, and the stricter criteria for classification have changed these statistics. Newer information on sarcoid, Brucella, and especially toxoplasmosis has improved our knowledge of the etiology of uveitis.

Uveitis is classified into two groups: a) Nongranulomatous, which is currently considered to be an allergic, sterile response by ocular tissues to bacterial hypersensitivity; it is characterized by an acute onset with marked inflammation, followed by recovery with minimal residual damage if seen early; and b) Granulomatous, where there is a direct invasion of the ocular tissues by the offending (nonpyogenic) organism. There is typically an insidious onset with marked cellular infiltration, tissue destruction, and late repair by connective tissue. The purpose of establishing these two categories is to provide a possible clew to the etiology.[2] Some cases have characteristics of both types of uveitis. An organism that produces signs of granulomatous disease also may cause sufficient hypersensitivity to produce a nongranulomatous (allergic) reaction. Contrariwise, repeated episodes of nongranulomatous disease eventually may mimic a granulomatous process.

After establishing the diagnosis of uveitis and classifying the type, a careful and thorough history should be taken and an etiological search initiated. The ophthalmologist should guide the survey and channel the investigation into specific fields, arrange consultations, analyze the laboratory studies, and summarize the results to make a positive diagnosis whenever possible.[3] He must decide whether the positive findings are related to ocular inflammation or are evidence of a previous unrelated infection. Uveitis specifically ocular in origin—phaco-anaphylaxis, or sympathetic ophthalmia—will not be considered here as the ophthalmologist should be able to recognize these entities.

Course of investigation

Studies for bacterial hypersensitivity or foci of infection may be omitted when the clinical picture is clearly granulomatous. When there is direct evidence of focal or acute infections directly related to the nongranulomatous uveitis, the survey for granulomatous processes also may be omitted. Otherwise, a search should include all the usual causes of uveitis.

The first day, take a complete history. Look for any evidence of previous ocular disorders, their relation to systemic disease, prior therapy, and the response. Exposure to tuberculosis or a history of family infection is important. Rule

From the Department of Ophthalmology, Northwestern University Medical School, Chicago, and The Evanston Hospital, Evanston.

out the possibility of congenital syphilis or other venereal disease. Question the patient about past travels and exposure to rare diseases, parasites, and infections; about recurrent fevers, lassitude, malaise, and allergies. Keep in mind the possibility of foci of infection regarding the status of the teeth, tonsils, genitourinary system, upper respiratory infections, and arthritis.

On the same day as the history is taken draw blood for serology, Brucella agglutination, albumin-globulin ratio, and the Sabin methylene blue dye test. Then make a skin test with tuberculin.[5] Arrange appointments with a competent medical man familiar with the implications of uveitis, an otolaryngologist, a urologist (or gynecologist), and a dentist. X-rays should be taken of the chest, sinuses, and teeth.

On the third day, the tuberculin skin test is read, the x-ray reports are checked, and the intracutaneous tests with toxoplasmin and histoplasmin are performed.

On the fifth day, read the toxoplasmin and histoplasmin skin tests, review the consultants' reports, and do an intracutaneous test with brucellergin. If foci of infection are reported, arrange for their removal and culture. If suspicious nodes are reported, biopsy is indicated.

Interpretation of results

A positive serology may be a biologically false positive. A luetic individual may have uveitis from another cause; therefore, other causes must be ruled out. A negative serology may indicate an inadequately treated case, but the history, examination, and spinal fluid results should aid in diagnosis. A positive history of syphilis frequently is denied. Newer tests reduce the incidence of false positive tests.

Diagnosis of tuberculous uveitis is difficult to establish. The clinical course may suggest or rule out ocular tuberculosis. Other causes of granulomatous disease should be eliminated. Evidence of previous tuberculosis is not necessary to establish diagnosis. The hilar glands are the most frequent source of ocular involvement. Only 50 per cent of patients with a presumptive diagnosis of ocular tuberculosis have roentgenologic evidence of a previous pulmonary infection. An active tuberculous process in the eye does not always produce a high cutaneous sensitivity; the skin test may be negative in tuberculous uveitis. Thirty per cent of those with ocular tuberculosis have low or absent cutaneous reactions.[4] A negative skin test, therefore, is of no diagnostic significance.

Tuberculin testing should always be done with weak strengths to avoid precipitating severe ocular reactions in those with a high sensitivity. A strong skin sensitivity is associated with a high ocular sensitivity. Not infrequently, in confusing cases where tuberculosis is suspected, streptomycin-dihydrostreptomycin plus para-aminosalicylic acid (PAS) and isoniazid are given for a minimum of 21 days. If improvement occurs on this therapy, the regimen is continued for a minimum of four months.[5] Desensitizing tissues with tuberculoprotein rarely is used today.

Diagnosis of brucellosis in uveitis usually is a presumptive one. The history and clinical course may suggest the diagnosis. In the chronic stage of the disease, when the eye signs appear, a titer of 1:40 is of diagnostic significance. Agglutination tests after skin testing with brucellergin are worthless. In chronic ocular brucellosis the cutaneous sensitivity usually is high, but a positive test indicates only that the patient had brucellosis at one time, may have fully recovered.

Sarcoid is an important cause of ocular disease. The clinical picture is important. The disease may be limited to the eyes or only to certain lymph glands. Ocularly, nodular iritis is almost always pathognomonic. A positive lymph node biopsy makes the diagnosis definite but a negative biopsy does not rule out the disease. Systemic signs are lymphadenopathy, cutaneous nodules, radiographic changes in the mediastinum and phalanges, anergy to tuberculoprotein, and elevation of the serum globulin.

Leptospirosis patients have an incidence of 10 to 40 per cent involvement with recurrent granulomatous iritis. Iritis begins typically four to eight months after recovery from the acute symptoms of headache, prostration, fever, and myalgia, frequently associated with jaundice or hemorrhagic phenomena. Diagnosis is aided by agglutination titers and complement fixation reactions. Positive cultures of the aqueous have been made for leptospira.[6] This is a rare cause of uveitis.

Toxoplasmosis usually manifests itself as chorioretinitis; rarely ever, as iritis or iridocyclitis. The eye is involved in the chronic late stage of the disease when the patient is otherwise

asymptomatic and the antibody level is low and stable. Most adults cannot give a history of a positive diagnosis because the acute stage of parasitemia, slight fever, and lymphadenopathy usually are unrecognized. Retinal lesions are produced in the chronic stage when retinal cysts, lying dormant for years after the acute stage, rupture and release organisms and antigen to cause allergy and necrotic reactions. Specific antitoxoplasmic chemotherapy is required to prevent scarring in the macular regions for which these lesions have a predilection. Titer of serum antibodies does not have to be high to justify a presumptive diagnosis of toxoplasmosis. If both skin test and dye tests are positive, the diagnosis is highly suspicious.[7] Some authors believe this etiology is responsible for 35 per cent of all cases of retinochoroiditis.[8] Treatment consists of the corticosteroids, the sulfonamides, and pyrimethamine. Repeated blood counts are necessary because of the danger of toxic depressions of hematopoiesis during therapy. Diagnosis usually is presumptive, based on failure of the chorioretinitis to respond to antituberculous therapy and because of a favorable response to toxoplasmic drugs.

Trypanosomiasis is another protozoan infection that leads to intra-ocular inflammation simultaneously with systemic manifestations. It is one of the more common causes of uveitis in Africa, but is almost unknown in America and Europe.

Fungi are known to invade the eye in living forms. Diagnosis usually is established histologically after the eye is lost. Among causative fungi recorded in the literature are: Aspergillus, Actinomyces, Blastomycetes, Cryptococcus, and Mucoraceae. Probably the most important fungus in the etiology of uveitis is Histoplasma capsulatum. Nonfatal cases are characterized by anergy to tuberculin, pulmonary calcification, and a positive histoplasmin skin test. Typically this disease causes scarring in the choroid.

Viruses as a cause of uveitis must be listed under the heading, undetermined origin, unless isolated from the ocular fluids. Herpes simplex and lymphogranuloma venereum viruses produce iritis or iridocyclitis. These viruses multiply and can be recovered from the aqueous. The viruses of Newcastle, influenza, Behcet, and the Vogt-Koyanagi-Harada syndrome produce toxic iritis but do not multiply in the eye. Diagnosis frequently is made by the presence of coexistent systemic changes—i.e., aphthous ulcers, spinal fluid changes, vitiligo, dysacousia, and alopecia.

Nematodes occasionally have been found to cause granulomatous unveitis. Usually the diagnosis is made pathologically; the parasites rarely are observed clinically. Unless the history is suspicious, it is seldom worthwhile to investigate this infrequent cause.

Nongranulomatous uveitis

The original idea of bacterial metastasis and absorption of toxins from foci of infection has been discarded. The evidence now supports the theory of bacterial hypersensitivity as the essential factor responsible for the ocular reaction. Foci of infection cannot be ignored if attacks of uveitis coincide with flare-ups of the focus or if there is a positive skin reaction to a test dose, employing an autogenous vaccine made from a focus of infection.

It is the ophthalmologist's duty to decide whether the presence of foci of infection or other physical defects or diseases should be specifically treated or removed. The opinion should be based on the belief that the infection is related to the uveitis. Certain evidence turned up in the diagnostic survey may be unrelated to the ocular disease and these individuals must be protected from unnecessary surgery and/or treatment.[9]

If bacterial hypersensitivity is responsible for uveitis, there are three possible courses: 1) Block the ocular reaction with steroids; 2) Remove the specific hypersensitivity (foci of infection); or 3) Use desensitization.

Circumstantial evidence suggests that a large percentage of patients with nongranulomatous uveitis have had prior infections with streptococci. The number of antigenic foreign proteins to which humans can develop hypersensitivity is myriad, and it is impossible to investigate all possibilities. Demonstration of specific bacterial hypersensitivity is not necessarily prima-facie evidence that it is responsible for the ocular reaction. All factors must be considered before assuming that the specific bacterial sensitivity is the actual cause.

Therapy

Until we reach the time ultimate goal of specific therapy in all cases of uveitis, nonspecific measures remain an important part of the manage-

ment. Salicylates are useful to decrease pain, but their specific action is not well delineated. Antibiotics as nonspecific agents are completely ineffective. Nitrogen mustard is being used successfully in a research project to inhibit intra-ocular inflammation, but the results are too limited to draw any conclusions. Phenylbutazone may be indicated in certain instances where steroids are contraindicated but its toxicity should be appreciated. Foreign protein therapy is still used, although since the advent of the steroids, its popularity has decreased. The current consensus favors high doses of systemic steroids for limited periods, reserving fever therapy for cases where steroids are contraindicated.

Conclusion

The changing concepts on the etiology of uveitis are reviewed. A suggested plan for a systemic search is outlined. The interpretation of the results of the survey is discussed, outlining the pitfalls and the significance of the findings. When specific disease processes are discovered, the proper medical therapy is indicated to eliminate the source of uveitis. Nonspecific measures still have a place in the therapeutic regimen of uveitis so long as there is a significant number of patients in whom no specific etiology can be determined.

REFERENCES

1. Wadsworth, J. A. C.: Uveal Tract Diseases, Annual Review, A.M.A. Arch. Ophth. **57**:457 (Mar.) 1957.
2. Calsoun, F. P., Jr.: Uveitis As A Medical Problem, Postgrad. Med. **17**:245 (Apr.) 1955.
3. Woods, A. C.: Endogenous Uveitis. Baltimore, Williams & Wilkins Co., 1956.
4. Woods, A. C.: Endogenous Uveitis. Manual of Am. Acad. Ophth. & Otol., 1949.
5. Kratka, W. H.: Isoniazid & Ocular Tuberculosis, A.M.A. Arch. Ophth. **54**:330 (Sept.) 1955.
6. Beason, P. B.; Hankey, D. D.; and Cooper, C. F., Jr: Leptospiral Iridocyclitis, J.A.M.A. **145**:229 (Jan. 27) 1951.
7. Frenkel, J. K., and Jacobs, Leon: Ocular Toxoplasmosis, A.M.A. Arch. Ophth. **59**:260 (Feb.) 1958.
8. Cassady, J. V.: Toxoplasmic Uveitis, A.M.A. Arch. Ophth. **58**:259 (Aug.) 1957.
9. Leopold, I. H.: Recent Advances in Ocular Therapy. Year Book of Ophth. pp. 13-27. Edited by D. T. Vail, Chicago, Year book Publishers, 1958.

Role of the Diet in Athletic Conditioning (Abstract)

Warren R. Guild, M.D., *Associate in Medicine, Harvard Medical School, Boston*

The need for an adequate diet for the population as a whole has been recognized and studied for centuries. Although varying cultural patterns alter the various dietary patterns throughout the world, good nutrition is possible provided an adequate supply of food is available. For many reasons, however, the athlete is not pictured as falling into the same pattern of his own cultural milieu but rather stands to one side as a creature requiring supranormal nutrition.

Good data have been collected in several areas of nutrition and athletics. A vast amount of information now is available regarding the optimal caloric intake for athletes who are participating in various types of sports, realizing that some sports make greater caloric demands than others. It is fairly simple to determine caloric needs since this is directly related to fluctuations in the body weight, which is a simple parameter to measure.

Another area which presents few practical problems is the need for fluids. Here again, not only is the body weight of some help but the athlete's thirst mechanism undoubtedly is a more accurate reflection than the measurements of the most skillful scientists. Also, the electrolytic needs of the athlete are well understood now that measurements are available of electrolytic excretion both by the urine and by the sweat.

There are large areas, however, where we have no adequate data. First are the inadequate studies for assessing the optimal composition of the diet for the athlete as it relates to the relative proportions of fat, protein, and carbohydrate. Moreover, the relative merits of the various types of proteins ingested in regard to muscle building propensities are as yet unknown. Finally, the need for a more basic knowledge of the functions of vitamins and of their role in athletic nutrition is of great importance. Confusion and misconceptions surrounding the need for dietary supplementation have resulted because these areas do not lend themselves to precise documentation and because direct data have not been obtained from researches on athletes themselves. Rather much of our currently useful information relates not to athletes but to studies performed on other groups, such as lumberjacks and factory workers.

Clinical-Surgical Conferences



Surgery for Essential Hypertension

Department of Surgery, Cook County Hospital

Moderator:
Robert J. Baker, M.D.
Associate Director, Department of Surgical Education, Cook County Hospital

Discussants:
Harold C. Voris, M.D.
Clinical Professor of Surgery (Neurological) Stritch School of Medicine of Loyola University; Senior Attending Neurosurgeon, Mercy Hospital

S. Howard Armstrong, Jr., M. D.
Director of Biological Sciences and Medical Education, Cook County Hospital; Professor of Medicine, University of Illinois College of Medicine

Dr. Robert Baker: The conference this morning deals with surgery for essential hypertension. We will try to exclude from the discussion those instances that are not true essential hypertension.

It has been estimated that one-fourth of the adult population of the United States has elevated blood pressure in some form; the vast majority of this group comprises the so-called essential hypertensives, in whom one or several mechanisms, as yet not well defined, are active in producing elevation of diastolic blood pressure.

The ravages of sustained hypertension are well known to us, and the deleterious effects on heart, kidney, brain, and eyes are all too frequently seen in every phase of medical practice. Despite lack of definitive knowledge on basic mechanisms of the production of hypertension, our therapeutic aims are directed at lowering blood pressure, specifically, diastolic pressure.

One therapeutic modality available is surgery, and we shall discuss indications for and methods used in surgical treatment of essential hypertension.

We are most privileged to have Dr. Harold Voris with us today. He was a staunch supporter of this institution from 1934 to 1950, having been on the staff in various capacities during that period. He was trained in neurosurgery by Dr. Adson of the Mayo Clinic, who was one of the foremost protagonists of surgery in hypertension.

The other discussant, Dr. S. Howard Armstrong, really needs no introduction. Aside from his other appointments, he is director of the Renal Clinic, and his experience and ability in renal diseases and hypertension make him an extremely apt choice in the discussion here.

Case 1

Dr. Carl Lum (Surgical Resident): The patient was a 54 year old white male truck driver who was admitted to the medical service with complaints of sweating, palpitation, extremely difficult breathing, and apprehension of several hours' duration. He had known he had hypertension for about a year and had been taking pills for high blood pressure, but no heart medicine.

Physical examination revealed a blood pressure of 200/100 mm. Hg and a pulse rate of 86 per minute. The fundi showed bilateral AV nicking, fresh hemorrhages, and one old exudate. A grade I systolic murmur and slight cardiomegaly were noted. Dyspnea was not present. Repeated blood pressure readings on succeeding days

ranged from 240/140 to 220/120 mm. Hg in both arms. Reserpine and Diuril® were started; Apresoline® and phenobarbital were added after several days in the hospital.

Urinalysis showed 1+ albumin; BUN was 25, creatinine 2.1mg., Regitine® test negative, creatinine clearance 56.4%. Serum potassium ranged from 2.7 to 3.4 mEq/L. Intravenous pyelogram revealed prompt bilateral function; maximum urine concentration was 1.022. Blood pressure, standing, ranged from 180/120 to 160/96 mm. Hg on therapy. Surgical consultation was requested.

The general problem

DR. BAKER: Dr. Armstrong, we will call on you first for a general discussion of the problem of hypertension as it is seen here, and an outline of the further work-up you would recommend.

DR. S. HOWARD ARMSTRONG, JR.: Hypertension as seen in the Cook County Hospital is much more unusual than that seen at the Mayo Clinic, where Dr. Voris was trained, or in Boston where I had part of my training, or at Massachusetts Memorial, where Smithwick does his work. You have people presenting at County who say, "I was fine until six weeks ago," but in their eyes there is a burst of flowers where there should be an optic disc, and the BUN happens to be 55. By Smithwick's rules (original and revised), they are not admissible for any type of surgery.

I want to talk a little about the classification of hypertension because that is important in determining whether any of these patients should be considered candidates for surgery. In the first place, in the early 1930's hypertension was classified according to eye-ground findings as grade I, II, III, or IV. In the late 1930's, after Smithwick developed his procedure and after the group Dr. Voris worked with decided they could not work with eye grounds alone, Smithwick added evaluations of the cardiac status and renal status and of whether there had been any arterial spasm in the head or elsewhere in terms of occlusive disease. And in this manner they decided that they did not want to operate on Smithwick's grade IV. This decision was made because they had a mortality in this group that was different from the mortality in grades I, II, and III; it was significantly higher than the 1 or 2 per cent that one ordinarily considers a reasonable mortality rate with sympathectomy.

The Smithwick classification often has been criticized warmly by Grimson at Duke University. He says it cannot be done this way. He says that if he is going to classify hypertension, he will take this classification plus the man's race. You know that, at County, accelerated malignant hypertension is a different disease in the Negro from that in the Irish or the Jewish patient. Grimson wants to know the patient's heredity in terms of who in his family has had hypertension or one of its complications. He wants to know about the man's wife because of the psychosomatic aspects of hypertension, and because hostility bothers the vascular system. He says that you cannot classify hypertension, but I think you can if you use the classification that Dr. Smithwick put down as basic and then put down *one other factor*: a period of observation of the hypertension before you decide what you are going to do. In the days prior to potent drugs, I never sent a hypertensive to surgery until I could see for four months what was happening to these things Smithwick has said are basic (unless the situation was an emergency); so I do not think you should say that hypertension cannot be classified.

Let's talk about this first patient. Here you have a 54 year old fellow who is hypertensive for one year, and his diastolic is not dangerous at first; he has fundi that do not show a large flower where the disc should be. He has a creatinine which is only slightly elevated, and his clearance is half normal. If you rule out unilateral renal disease, he may be a candidate for surgery or perhaps be handled on medical management. One of the most important things to consider is: Will this man stick with medical management? To manage a hypertensive patient medically can be as hard as managing a brittle diabetic. You know about the dreadful problem of adjustment of drugs. If the patient would come in regularly he might be managed; but if he is the kind who will not come in regularly, he might do better with surgery because it will take less medication to handle him, if he is properly sympathectomized. In private practice you might decide to handle such a patient by medical therapy.

DR. BAKER: Is it always easy to classify the patient from the information you gave, and is not this classification somewhat arbitrary in this instance?

DR. ARMSTRONG: He is grade II Smithwick,

but I want to say one other thing. Smithwick says you must not operate on grade IV because of the high operative mortality, but I have had about eight patients of this type operated on here is Chicago. They were persons in whom the situation was desperate. It was explained to them that the mortality rate, where there was significant renal failure, goes from 5 to 40 per cent and that many surgeons would not touch them. Smithwick will not touch them at all. Of these grade IV patients, three of the eight died; but of the survivors, we have had one with an 8-year follow-up whose functional preoperative status was such that anyone would have said he would be dead in six months. We have others with three to five-year follow-ups.

Given the manifold risks, I think it is worth going to surgery for this kind of result. If you make it clear to the family and patient and face the mortality with the same philosophy that applies to radical carcinoma surgery, you will salvage an occasional patient.

Dr. Baker: Certainly, the malignant course seen in patients with a rapidly progressive disease makes their status similar to that of a patient with a rapidly-growing neoplasm. What about a diastolic pressure of 130? Is that a surgical level? If the patent has a blood pressure reading of 220/120 mm. Hg, will you advise operation?

Dr. Armstrong: If he stays at 120 and is a young 28 year old who could have a long life, I would have him sympathectomized. If he is 60 years old, I would work with him for a while. I believe this is what Grimson means. It becomes a matter of individualized diagnostic appraisal. You may use a classification, but you have to use other things too. The diastolic pressure is not the sole criterion; indeed, there is no sole criterion. No appraisal, however detailed, done at one point in time, ever leads me to recommend surgery, or, indeed, not to. The most important consideration is the *rate of progress* of hypertensive manifestations over a period of time as appraised against the background of what is going on in the patient's life.

Dr. Baker: Dr. Voris, we would like to hear your approach to this problem.

Dr. Harold C. Voris: It is really a pleasure, in fact a thrill, to come to this amphitheater again this morning. My initial experience with this place began in 1928, and until 1950 I had been here a great many times.

I should begin my remarks by saying that my experience with sympathectomy in hypertension does not warrant my being on this program. I have not done many sympathectomies for hypertension. We have steadily done a few over the years at Mercy Hospital. I think we are doing almost as many as we did in the 1940's, largely because we are now getting some patients referred to us by our medical colleagues who feel there is a place for sympathectomy in the treatment of hypertension. I can assure you that our patients have been well studied and observed over a period of time, because the medical men do not refer cases to surgery until the patient has been studied carefully. I agree with everything Dr. Armstrong said about observation of the patient over a period of time.

From a practical standpoint, in the selection of cases I have always been interested in the patient's resting blood pressure. I don't mean when he is sitting in a chair for an hour waiting to see you, but after he has been at bed rest for at least 24 hours, preferably 48 hours. Other specific tests I do not need to go into.

I was interested in what Dr. Armstrong said about surgery in the grade IV case. A patient I operated on some three or four years ago for Dr. George O'Brien was a man in his early 40's, an instructor in a technical college in the city. He was admitted to Mercy Hospital with a subarachnoid hemorrhage, and he almost died. When I was asked to see him, being interested in treatment of intracranial aneurysm, we did a carotid angiogram, which did not reveal any aneurysm or vascular malformation. He continued to improve slowly, but his blood pressure remained high and fixed throughout the four to six week period of bed rest. His BUN stayed high and he had severe vascular changes, some of which may have been associated with spontaneous subarachnoid hemorrhage. He had severe hypertensive retinitis.

I didn't want to do a sympathectomy on him, but Dr. O'Brien said there was nothing else to do, and why not try it; so eventually I did and, surprisingly, he went through the Smithwick operation in two stages very well and is still doing well. His pressure came down, whereas it had remained high and fixed for six weeks after the hemorrhage. He is just one of those persons whom it is impossible to fit into any classification.

I agree with Dr. Armstrong that you have to exercise your clinical judgment and select these cases as individuals and not on the basis of artificial grading standards.

Before the conference, Dr. Baker evinced interest in the fact that I had had some personal experience with the initial attempts to treat hypertension by sympathectomy at the Mayo Clinic in the early 1930's. Perhaps the rest of you would be interested in hearing about these attempts. Dr. Adson had been interested in sympathectomy since the late 1920's, but his initial attempt to treat hypertension with anterior rhizotomy was in 1930. I was his assistant when he performed his last rhizotomy, and I think that experience was responsible for (A) his giving up the procedure and (B) his being unwilling afterward to do any operation for hypertension which did not permit him to explore the adrenal gland.

The young woman had come in because of severe hypertension. After thorough work-up with all the procedures available at that time, she was referred to Dr. Adson for surgical treatment. He had had a previous and unpleasant experience, before I began my fellowship there, with rhizotomy for hypertension in a patient who was permanently paraplegic thereafter, and I know he did this operation with reluctance. The first day before the patient could be intubated her systolic pressure was 300 mm. Hg. She was returned to her room, kept under sodium amytal for several days, and then Dr. Adson did the first stage thoracic laminectomy with section of the anterior roots of T-6 through T-10 on each side. The patient never wakened. At necropsy she had a large adrenal tumor. That was the end of rhizotomy for hypertension so far as Dr. Adson was concerned, and furthermore, it resulted in his not being willing to perform any operation for hypertension that would not permit him to examine the adrenal gland; so he used surgery below the diaphragm.

Another case I would like to speak of briefly is the first sympathectomy for hypertension at the Mayo Clinic carried out below the diaphragm by Dr. Craig in 1933. I was his first assistant, and I can assure you we had a hard time finding the splanchnic nerve on that side; it was a real ordeal. It was not very long before Dr. Adson had evolved a procedure, which he continued to follow, that consisted essentially of resection of the splanchnic nerve below the diaphragm. Initially he did partial adrenalectomy but later substituted extensive resection of the celiac ganglion. Peet at Ann Arbor reported his first sympathectomy above the diaphragm in 1934 and then proceeded to perform a large series.

Dr. Armstrong told you that Smithwick, after initial trial of both operations, settled on a combined operation including the sympathetic chain from T-8 through L-2, plus the splanchnics, and this was extended by Poppen and finally by Grimson to include the entire sympathetic chain from T-1 to L-2, in addition to the splanchnic nerves. Peet's operation initially included only the lower ganglia, but eventually went up as far as T-8. Adson's operation was basically L-1 and L-2 section, with splanchnicectomy. Then the combined operation extended from T-8 to L-2; this was the Smithwick procedure. Poppen is a great technical surgeon and can perform his extensive operation more rapidly then most of us can perform a more limited one.

In my own experience I have had the most satisfactory results with the Smithwick operation, but I have done the Adson and Poppen procedures several times. It is generally agreed that the Adson is not adequate. On the other hand, it seems that the very extensive sympathectomy adds too much to the morbidity of the procedure and too much to the occurrence of complications, so, as far as I am concerned, the Smithwick operation is the one I have settled on, and have done nothing else for five or six years. I have never done a transthoracic procedure as I do not feel as much at home in the chest as I would like.

I do not think that I can add anything to the contraindications to surgery that are listed on the second sheet given you [heart failure, recent cardiovascular accident, severe angina, and renal failure], nor can I add anything to what Dr. Armstrong said about selection of cases. Obviously people who have been satisfactorily managed from the medical standpoint are not candidates for surgery, and only the most anxious surgeon would consider that they were. Of course, it is convenient to be rather dogmatic about contraindications and say that cases of cardiac failure or renal failure or recent cerebrovascular accident should not be operated upon,

or severe angina pectoris. Actually, as both Dr. Armstrong and I have indicated, there may be exceptions to the rule in which surgery should be undertaken only after careful consideration.

Physiologic effects

Dr. Baker: Dr. Voris' modesty in disclaiming a great experience is not well accepted since he has written extensively on surgical treatment of hypertension. Dr. Armstrong, what do you think sympathectomy accomplishes? Does it accomplish a simple mechanical reduction of blood pressure? Is there increase in renal blood flow? Is this mechanical lowering of pressure enough, or is there some other effect which we have not touched upon as yet?

Dr. Armstrong: That is a matter of argument. The study done at Smithwick's laboratory showed that immediate postoperative filtration rates and renal blood flow were not greatly different from the preoperative findings; but although you do not get a reliable fall in resting blood pressure, the progress of vascular lesions that kill the patient is in some way held up. This has been explained on the basis that the physiologic response that one gets, due to postural changes, is blocked. Many presumptive blood pressure rises that occur when no one is measuring are blocked; for instance, your blood pressure may go up when you are angry or when the Valsalva maneuver is done. If you do a Valsalva on a properly sympathectomized patient, the blood pressure does not go up. This stabilization in daily life may be a key factor in preventing progress of vascular damage.

Again, it has been shown clearly that the development of arteriosclerotic lesions occurs at a faster rate in the presence of consistent diastolic hypertension, and when you have this diastolic hypertension partially reduced the incidence of complications related to plaques in arteries may be reduced. Grimson has said that if we could eliminate all sympathetic impulses originating from T-2 down to L-2, there would be a good deal less chance, in response to various types of stress, of producing adrenalin. Immediately, when we do that we may jump over the fence and say, Why not take the adrenal out? There is a strong school in favor of adrenalectomy for hypertension today, championed by Dr. Zintel in New York.[2]

Dr. Baker: Dr. Voris, would you comment on whether you think the sympathetic chain, as Grimson says, stimulates some eccentric source of adrenalin? Also, do you examine the adrenal routinely?

Dr. Voris: I cannot answer the first question because I have not been able to carry out that type of study in the majority of cases I have treated. What sympathectomy does to these patients is a fascinating question. I am glad that no one has used the term "neurogenic hypertension," because nobody knows what that is in the human being. Actually, there have been one or two reported cases of neurogenic hypertension in man but without survival for a period of time sufficiently long to determine whether the hypertension would persist. Bucy called attention to the fact that if you watch a patient's blood pressure while he is having resection of the glossopharyngeal nerve, there would be a rise in blood pressure, but that rise is always transitory. It is due to the fact that severing the parasympathetic nerves (of the cranial outflow) is tantamount to sympathetic stimulation.

Trigeminal neuralgia is bilateral in a small percentage of cases, ranging from 0.5 to 6 or 8 per cent, but in any case, the total number of bilateral trigeminal neuralgias is very small. No case of bilateral glossopharyngeal neuralgia has presented itself to a surgeon, so we don't know whether it is justified to section both glossopharyngeal nerves. Both have been resected for treatment of pain from malignant disease in the throat, but those patients are hardly satisfactory experimental subjects because they have been so debilitated from disease that rise in blood pressure may have been forestalled. A rise was reported in one case, but the patient did not live long enough to determine whether it was a lasting rise. So we don't know what neurogenic hypertension is, in man. However, I believe that sympathectomy can take away to some extent the ability of the blood pressure to respond to emotional stimuli.

As to your second question about exploring the adrenals, I do not do this routinely in the sense of probing them, but I do explore them by palpation.

Dr. Baker: Our first patient had a bilateral Smithwick procedure and both adrenals were found to be normal. His blood pressure following operation was, supine, 160/94, standing 120/84

mm. Hg. Which is the more significant of these two readings? The main difference is in the systolic pressure.

Dr. Armstrong: That is a good result. The diastolic lying down is the hardest in which to obtain a satisfactory response. It will be easier for this gentleman to live a long life.

Dr. John Boswick (Surgical Resident): The patient was a 36 year old Negro male admitted from the county jail because of "hypertension." He had been hypertensive for 14 years; he was accepted by the Army for service in 1943 but was told of his high blood pressure on discharge in 1945. He had been well except for occasional "lightheadedness" and headache following exercise. The patient was given medication for hypertension some four years prior to admission, but had taken medication for only three months.

The patient's mother had died of a stroke at the age of 42; two brothers and a sister had died of "high blood pressure."

On physical examination the patient had a blood pressure of 260/170 mm. Hg, pulse rate 72 per minute. Moderate AV nicking was present, and one round hemorrhage was seen in the right fundus. The left heart border was at the anterior axillary line. No other abnormalities were noted.

Urinalysis showed a trace of albumin and specific gravity of 1.018; the patient concentrated to 1.024. PSP excretion was 62% in 2 hours. Intravenous pyelogram was normal. NPN was 24, creatinine 1.2 mg. %; serum potassium 3.2 to 3.6. Urine albumin in 24 hours was 0.5 Gm. After two weeks of drug therapy the blood pressure was 170/120 mm. Hg.

Dr. Baker: I had occasion to take care of this man; he was a recalcitrant patient. He said that he knew he was going to die of hypertension so why take drugs? However, his obstinacy was tempered by the fact that he was in jail and he liked the hospital better, and when he found out that could stay in the hospital, he thought surgery would be fine. Dr. Armstrong, will you comment about the management of this patient's hypertension?

Dr. Armstrong: On this patient, I would want the adrenals explored. He is an ideal candidate for sympathectomy. The more recalcitrant he is, the more reason to offer sympathectomy, because he will not cooperate on medical treatment. Often someone will accept a violent thing when he is violent in personality, whereas he will not accept long-term treatment. He would be classified as Smithwick grade III. If you use all the things Grimson would like you to add to the Smithwick classification, he would get into Grimson grade IV, because of his family history and perhaps because of relationships with his wife if he is in jail.

He has everything that we use as a basis to determine whether to operate; some of our medical residents have made great pleas that they are not going to learn how to take care of hypertension medically if we refer people too early to you. But having watched the struggle in patients like this, trying to hold the blood pressure with drugs, knowing the manifold combination of drugs you have to use and the manifold side effects of these drugs in effective dosage, I would much rather take a bee-line to the surgeon and use drugs in lesser amounts after surgery.

Personality and age

Dr. Baker: At the age of 25, and with this personality, what would you do? This was the situation when his hypertension was first discovered.

Dr. Armstrong: That is a really tough question. There are people who have this degree of hypertension who live quite a while without serious trouble. How are you going to spot them in advance? If you can't, you may operate on a lot of people, and some unnecessarily. I would say to tell him to come back over the span of a year, but this man will probably not come back, so he will end up with another physician. I would not recommend operation for him without at least a chance to study him over a year and appraise the *progress* of his hypertensive manifestations.

Dr. Baker: This man had a bilateral Poppen procedure and two months later his supine blood pressure was 180/120 mm. Hg, whereas before surgery it was 240/170 mm. Hg. He had a severe postoperative neuralgia, as is not uncommon after extensive sympathectomy.

Dr. Voris: Severe neuritis postoperatively brings up the problem of surgical complications.

Pleural effusion is a common postoperative complication in the first postoperative week, and we frequently have to aspirate the chest. It is not of consequence over a long period of time; it usually clears up after aspiration, but you must be on the look-out for it. Remember that when you strip the pleura off the ribs, as you do in the Smithwick operation, there will be some change in the breath sounds and some dullness, with perhaps fluid; so I do not depend too much on physical signs, but rather on whether the patient is showing respiratory embarrassment. Intercostal neuritis is a different story, and I have tried everything that has been suggested. I have tried avulsing the nerves or sectioning them. We always try to protect them as much as possible, and I certainly don't know why we get this neuritis. The last case I treated had no neuritis on the side that I had severe technical difficulties with because of an old adhesive pleuritis, and I am sure there was more retraction on that side. On the other side, with moderate operative difficulty, there has been a severe neuritis. The condition can last a long time; generally, it clears up after a number of months. In one case we eventually did a laminectomy and posterior rhizotomy two years after sympathectomy. There are other complications and one is very dreadful; unfortunately, one of my patients had it: paraplegia apparently due to thrombosis of a spinal artery following drop in blood pressure.

Dr. Baker: Would this pressure rise in a short period of time discourage you? It dropped very quickly, but in two months it went back up.

Dr. Voris: However, his diastolic has stayed down. It is interesting that his blood pressure two months after operation is essentially what he had after two weeks of drug therapy. I must confess that if I had seen this patient initially, I would have thought he was not a good subject because I would have been frightened by that diastolic pressure of 170. When it drops 50 points after drug therapy, the situation is different. I agree that patients of this type are better off with sympathectomy than without, or attempting to keep them on medical management. Medical management can almost be predicted to fail in patients with personalities of this type. Medical treatment demands a great deal of cooperation and forebearance on the patient's part; and if he is not willing to give that, he may very well be a candidate for sympathectomy, even though you do not feel medical treatment has had adequate trial.

Dr. Baker: Would you have operated on him at 28?

Dr. Voris: I would have wanted the same period of observation that Dr. Armstrong mentioned. His remarks on that score cannot be too strongly emphasized.

Dr. Armstrong: Dr. Voris said he would be bothered about the pressure of 170. Some of you who want some fun in reading should sit down with the apparently uncensored panel discussion in last year's Hypertension Symposium in Philadelphia.[1] I think it was Dr. Grimson who said medical failure will be a surgical failure. He said he does not want to do these medical failures. Now everyone who plans sympathectomy with a diastolic of 170 will probably agree that some medical management is needed before surgery. But the significance of Grimson's remark depends on your definition of medical failure. There are patients with a presenting diastolic of 170 who with a mean diastolic of 100 cannot be satisfactorily maintained on medical management alone and who have a chance for satisfactory management with a combination of surgery *plus* medicine. If you can bring the initial high diastolic down somewhat, then you are in a position to operate. If you can't budge it medically, you are dealing with a member of that small but appreciable percentage of hypertensives for whom nothing can be done. The people who were sitting around that discussion table were reluctant to let Grimson off with his equivalence of medical and surgical failures without some definition of *degree* of medical failure. As a matter of fact, I strongly feel the other way (and my own personal experience in hypertension is certainly smaller than Grimson's in that I have never limited myself to working with any single group of diseases): the medical failure is just the patient who needs most consideration of surgery and needs it just as the medical failures in peptic ulcer management need consideration of combined therapy.

Dr. Voris, do you use in sympathectomy any temporary support with steroids? I would say that paraplegia is indeed a very rare complication. I would guess it must be less than one tenth of one per cent in the total literature.

Dr. Voris: I have not used steriods. When we had our case about eight years ago, we were able to learn of only 7 other cases, and not all these have been published. Our patient became paraplegic 48 hours after surgery. He was noted during the night to have low blood pressure, but he had not required supportive medication after surgery. What happened that night cannot be stated because the nurse did not recognize the paraplegia. He was an elderly individual in the upper age limit by any criteria, and he had a fair amount of arteriosclerosis.

Dr. Armstrong: Were his posterior columns intact? Was it an anterior spinal artery lesion?

Dr. Voris: As far as we could determine he had a transverse lesion.

Dr. Baker: I want to thank both discussants for this most illuminating presentation.

1 - Moyer, John H.: Hypertension. The First Hahnemann Symposium on Hypertensive Disease. W. B. Saunders Co., Philadelphia, 1959, pp. 716-723.
2 - Mackie, J. A., Zintel, H. A., et al.: A comparison of thoracolumbar sympathectomy and bilateral adrenalectomy-sympathectomy in the treatment of essential hypertension. Surgical Forum. W. B. Saunders Co., Philadelphia, 1954, pp. 169-172.

The Compassionate Physician

Frederick Stenn, M.D., *Chicago*

A. J. Carlson used to tell his students that physiology has no boundaries. Medicine too has no limits. Like the rays of the sun, our art extends its fingers into every phase of human activity. As practicing physicians, we soon learn that our services are not confined to the pathologic and psychiatric understanding of our patient, nor restricted to pill, hypodermic needle, or scalpel. We become increasingly aware of our role as friend and councelor and in that capacity are called upon to serve often as judge, lawyer, financier, philosopher, engineer, and social worker, even as a minister. We learn that we are treating not disease alone but man too.

Ludvig Hektoen exhorted his research workers to "follow through." If a fact is learned, explore it to its greatest depth, he would say. So too with the patient — the problem his illness presents is merely a small opening which leads, like Alice in Wonderland chasing after a rabbit, to a marvelous labyrinth; and the deeper we inquire, the more effective our therapy.

The dedicated doctor finds himself involved in all manner of activities. How frequently are we moved by the elderly widow with hypertension who asks, "Doctor, shall I sell my home or rent it?" Or the bewildered daughter, "Is it better for me to quit my job and care for my demented mother at home or shall I place her in a sanitorium?" Or the city employee desperately struggling against the effects of a manic depressive psychosis who earnestly asks, "Is a divorce the answer to my problem or a separation?" Or the butcher, pale and thin with cancer that has spread from the larynx to the lumbar spine who beseeches, "How can I look at death without fear?" Or the wife who says of her husband, confined at home by a stomach tumor, "Doctor, if you'll come around and just talk to him from time to time, he will be able to endure it."

To write a note of congratulation on marriage, and a note of consolation at death.

Each day somewhere a doctor grasps the shaking hand of an old man who has just lost his wife and attempts to impart into him the courage necessary to meet the lonely days ahead; whispers encouraging words to an expectant woman who is exhausted from an arduous and painful labor, sits hour after hour at the bedside of his critical coronary patient with words of cheer and hope, gives comfort to the family of a patient who had just undergone a surgical operation, and sets at ease a mother distressed with the cares of her newborn baby. These and a thousand other similar deeds physicians bring to pass silently and daily all over the world. The great leaders of our profession took pride in doing a kindly act, in expressing a gracious thought, in showing that someone cares. Osler, Mackenzie, Broadbent, Parkinson, Lettsom, Shippen, Wistar, Trousseau, Janeway, DaCosta, Weir Mitchell, Dieulafoy, and Diffenbach were of this stamp.

Is such magnanimity a part of the function of a physician? Yes, as much a part as a hammer is the tool of a carpenter. Strict attention to the scientific aspects of a patient is attention to only half of a man. Understanding with sympathy and tenderness and thoughtfulness is the other half. The combination gives the profession its nobility.

Development of Inguinal Hernia Following Appendectomy

James Scott, M.D., *Dwight*

The frequent development of inguinal hernia following appendectomy cannot escape the attention of a busy surgeon. The etiological relationship has been suggested under the principle that any abdominal incision weakens the structures of the abdominal wall.

In 1911 Hoguet found among 190 patients eight right inguinal hernias that had developed following appendectomies.[1] Exclusive of all "congenital and double acquired" hernias, the interval between the two operations ranged from two weeks to four years. In 1951 Lichtenstein and Isoe reviewed 567 patients with inguinal hernias and found 67 who had had appendectomies; these 67 cases included 40 right sided hernias and 12 bilateral hernias.[2] In a series of 1,357 inguinal hernias, Walker found a preceding appendectomy in 110 patients.[3] Following numerous publications, mainly in foreign languages, and statistical studies, the concensus was cautiously phrased by Seulberger and Peters that lateral abdominal incisions predispose to inguinal hernias, especially on the right side.[4]

A review of publications on this subject reveals a vagueness of the conclusions. The great frequency of appendectomies and inguinal hernias with the recognized predominance of right sided inguinal hernias makes it difficult to substantiate a cause-and-effect relationship in all cases. The multitude of etiological factors in the development of inguinal hernias reduces further the value of statistical figures.

Present study

This study is based on the records of 196 male patients with inguinal hernias treated at the Veterans Administration Hospital, Dwight, Ill., from 1957 to 1959. Their ages ranged from 22 to 70 years.

Department of Surgery, Veterans Administration Hospital, Dwight, Illinois.

Among 196 patients, 32 (16.3%) developed postappendectomy inguinal hernia, 12 on the right side, nine on the left; 11 patients had bilateral hernias.

All but three of the patients were more than 20 years old when they were operated for appendicitis. The remaining three were 11, 13, and 16 years of age. The hernia that developed was bilateral in all three instances. Since any damage to the structures of the abdominal wall is easily corrected by the growing body of the young child, inguinal hernias do not appear to be late complications of appendectomies in children. The fully developed muscle and fascia of adults, however, require perfect approximation and healing to prevent such a sequela.

The time interval between the appendectomy and the appearance of the inguinal hernia has ranged from one to 36 years. The appearance of the hernia within a short period of time appears to support an etiologic relationship.

Indirect hernias were predominant being present in 25 cases; two patients had both direct and indirect hernias. Appendectomy had been performed through a McBurney incision in 27 patients and through a low paramedian incision in five. Several incisions were placed low, in close proximity of the inguinal canal.

Nerve injury and abscess

A frequently mentioned factor in development of these hernias is damage to the segmental nerve supply of abdominal muscles during appendectomy. The resulting loss of muscular support is blamed for weakening the internal ring and the floor of the inguinal canal. While nerve damage may be a factor in some cases, we were unable to find clinical evidence of it manifested by bulging, toneless muscles. For this reason, we feel that incomplete approximation or healing of the fascial layers is a more important factor.

Both Hoguet and Pitkanen have noted an increased frequency of right inguinal hernias following prolonged drainage of an appendiceal abscess and following the development of an incisional hernia.[1,5] In this series, intra-abdominal abscesses were drained through a MeBurney incision in two cases. An incisional as well as an inguinal hernia developed in both instances.

Conclusions

Among 196 patients studied, lower abdominal incisions appeared to be a factor in the development of aequired ipsilateral inguinal hernias in adults when an intra-abdominal abscess required a prolonged drainage and when the hernia developed within a short period of time following the appendectomy. However, in the majority of cases, in spite of tempting simplieity of etiologic reasoning, a eause-and-effect relationship could not be established.

REFERENCES

1. Hoguet, J. P.: Right Inguinal Hernia Following Appendectomy, Ann. Surg. **54**:673, 1911.
2. Lichtenstein, M. E. and Isoe, I. M.: Right Inguinal Hernia Following Appendectomy, Am. J. Surg. **81**:436, 1951.
3. Walker, F.: Leistenbruch als Appendectomiefolge und Folge anrerer Traumen der Bauchwand, Wien med. Wchnschr. **104**:538, 1954.
4. Seulberger, P., and Peters, H.: Uber die Manifestation von Leisten-und Schenkelhernias nach seitlichen Bauchschnitten. Chir. **22**:257, 1951.
5. Pitkanen, A.: The Relation of Incisional and Inguinal Hernias as well as of Mechanical Intestinal Disturbances to Previous Operations for Appendicitis with Peritonitis, Acta chir, Scandinav. Supp. 138, **96**:1, 1948.

The Original Apothecary

The pharmaeist of today is the lineal descendant of the apothecary of the middle and late Renaissanee. The apotheeary was originally a storekeeper, largely a grocer who handled drugs in what modern verbiage would deseribe as a "department" of his store. In the early reign of James the First, the grocers and apotheearies constituted a single guild, but in 1617, James granted the apothecaries a charter of their own. There were 114 members of the original group, and they adopted a set of guideposts, resembling a code of ethics, among which were that each would fill the physician's "bill," the forerunner of our present day prescription, exactly as written, "meddle only in his own vocation" and remember that "his office is only to be ye physician's cooke." Although they had practically a complete monopoly on drugs, they were subject to inspection by the College of Physicians, who had legal authority to enter their premises, inspect their stoeks, and eondemn sueh of their wares as were adjudged of inferior quality.

There was a dearth of physicians, and the apothecaries not only counter-prescribed but actually practiced medicine and legally could perform a phlebotomy for one condition only, pleurisy. There was a definite danger in actual practiee by the apothecary, however, for if he undertook to treat a patient who died, the poor apotheeary was guilty of a felony. Hence it beeame customary in case of severe illness to call a physician consultant and refer the critically ill patient to him.

The aetual splitting of fees does not appear to have been done; but the physician usually preseribed generously, and the referring apothecary filled these prescriptions at an inflated price so that the drug bill was often larger than the physician's fee. It does not seem strange that, under such circumstances, banter, discord and dissension ran riot, and many charges and counter-charges of profiteering and overcharging were indulged in by both groups. There seems considerable evidence of profiteering on the part of at least some of the apothecaries, for there is a record extant of a charge of 30 shillings each for 25 pills. Certainly the criticism we so often hear today of the high price of drugs is not a phenomenon originating in the twentieth century.

The physicians were charged with greed also. In fact, the members of both professions in England were, as a rule, wealthy. The eustomary physician's fee was a ten shilling coin called an angel, and one wag among the apothecaries made the observation that a physician was like Balaam's ass; he wouldn't speak a word until he saw an angel. *Walter E. Vest, M.D. Medico-Pharmaceutical Relationships. West Virginia M. J. Nov.* 1959.

EDITORIALS

Indications for senile cataract extraction

A recent article states that cataract extraction has become the most frequent operation in the aged. This is partially due to the increased longevity of our population, but it is also dependent on the fact that two such operations can be performed on the average patient, in contrast to other geriatric procedures such as prostate resections and hysterectomies, where gender and uniqueness sharply limit the possibilities for surgery. However, the fact there *are* two eyes frequently confuses the issue when cataracts are present, and it is not uncommon to see patients who have received completely divergent opinions on the advisability of removing a monocular cataract.

When then should a cataract be removed? Two clear-cut indications for such surgury exist. The first may be called the objective indication, and it is the presence of a *mature or hypermature* cataract. This type may undergo various changes, all of which bode ill for the eye. Swelling of the opaque lens fibers may occur, with subsequent glaucoma due to narrowing of the angle of the anterior chamber. Disintegration of the lens fibers may follow, producing an iritis. A hypermature cataract may even dislocate, making its removal much more hazardous than the routine cataract extraction. For these reasons a *mature* cataract should always be removed regardless of the visual state in the fellow-eye.

The second clear-cut indication for cataract extraction is the presence of bilateral cataracts where the vision in the better eye is below the patient's needs. This may be called the subjective indication, and it is obviously variable. The illiterate workman may get along very well for many years with 20/100 vision in his better eye. The jeweler or machine tool operator, on the other hand, may require surgery when the vision in his better eye falls to 20/40 or 20/50. Note that the important factor is the vision in the *better* eye.

Why is the vision in the poorer eye ignored? The answer to this lies in the postoperative optical problems of cataract lenses. In the average patient with a good surgical result, aphakic lenses will magnify objects about 33 per cent. Conversely, if the unoperated eye has good vision, it will see an image one third smaller. This results in an intolerable diplopia which can be overcome in two ways. One can allow the patient to continue using his unoperated eye by simply not prescribing a correcting lens for the aphakic eye, or one can correct the aphakic eye and block off the unoperated eye with a strong plus sphere. In both instances the patient has essentially monocular vision. Note that this is exactly the condition that existed before surgery, so that in essence the patient is no better off after surgery than he was before.

In all fairness, we must present the arguments of those who advocate removing a monocular cataract. First, they state that the field of vision is improved. This is true. The improvement in side vision is about 15 per cent due to unobstructed lateral vision. This slight increase in field is rarely of great advantage to the patient, since most people prefer to turn their heads to gaze at objects in the extreme periphery.

Secondly, one may prescribe a contact lens for the operated eye which reduces the image disparity to 2 or 3 per cent. This is tolerable and does allow binocular vision for distance. (A reading glass or bifocal lens will still have to be used for close work.) Furthermore, few patients are willing to put up with the nuisance and foreign body awareness of a contact lens when without such a device they can see well with their unoperated eye. However, the whole field of contact lens fabrication is undergoing

rapid change and more satisfactory lenses are being reported daily. None is as yet ideal.

Finally, there is the recent introduction of intraocular plastic lenses which, theoretically, do away with all postoperative optical problems. This is mentioned only to be strongly condemned. The incidence of postoperative complications is high, and the introduction of a foreign body into the eye can be considered only an experimental procedure at this time. Routine cataract extraction has become a safe, effective operation in most cases. Occasional complications do occur as with any surgical procedure, but great strides have been made in recent years in preoperative preparation, anesthesia, sutures, postoperative care, etc., so that complications are becoming fewer and fewer. The introduction of a foreign plastic material into the eye is at present a step backward.

In summary, then, two chief indications exist for the extraction of the ordinary senile cataract. *One,* the presence of a *mature* or *hypermature* cataract in one or both eyes and *two,* the presence of binocular *immature* cataracts where the vision in the better eye is less than the patient's needs.

David Shoch, M.D.

Rehabilitation

During the past ten years there has been a rapid growth of interest in rehabilitation among both professional and lay citizens of Illinois resulting in development of physical facilities and programs known as Rehabilitation Centers. In addition to patient services, these Centers have developed teaching and research programs. There are four Centers in Chicago and Peoria. [See Reference Sheet.]

Rehabilitation includes physical, psychological, social, economic, and vocational evaluation and treatment. To successfully accomplish these objectives, full cooperation and support of the medical profession, local and state agencies, industry and business is mandatory. No citizen, regardless of his social or vocational relation, is excluded. Expansion of the Rehabilitation Center services has and will depend on the support of the medical profession and the rapidity with which follow-up programs develop. Our centers are having the full cooperation of the Division of Services for Crippled Children, Division of Vocational Rehabilitation, and Illinois Public Aid Commission. Their interest and support has aided materially the success of the programs.

What is a Rehabilitation Center? Who needs it? How does it function? Rehabilitation used singularly has different meanings for different people. Rehabilitation is a popular word because Federal and State legislation has made monies in large quantities available to those who have developed plans and programs to meet a need.

The key word in rehabilitation is need. Rehabilitation is a process in which we meet or attempt to meet the needs of the group to which we are referring. Major objectives are focused on disabling problems resulting from illness or injury.

Illness is defined as the absence or loss of health, and the concept of health is a matter of "interest." The more interest we have in the things and people about us, the greater the degree of health; and conversely, when this interest is lost or turned inward, a condition we term illness or absence of health exists. When this loss of interest is indefinite or of great duration, we have the condition of "chronic illness."

If we apply this definition to the patient population referred to Rehabilitation Centers for evaluation and treatment, we note that the illness invariably starts with an acute episode such as amputation of an extremity, an acute traumatic problem, a spinal cord injury, or fractured hip. A cerebrovascular accident, coronary, or the exacerbation of multiple sclerosis are examples of acute onset from illness. These conditions are usually short lived, but the manner in which the patient can accept the residual disability determines whether he will be chronically ill or return to a state of health. As a result, the illness per se and the extent of the residual disabilities are not necessarily key factors in determining whether a patient is chronically ill. Other factors determine the pattern.

We are dealing with persons who have lost interest in people or things about them. To recapture it, patients' needs must be determined. This is the primary objective of rehabilitation center programs. Within practical limits, the services to evaluate, expedite, and meet their needs are integrated in the center.

The successful consummation of the patient's rehabilitation program is the direct responsibility of the physiatrist.* He also supervises the formulation of policies and technics to improve and

expand the center programs. The entire staff works as a team to meet the patient's rehabilitation goals, which must include a satisfactory solution to his physical, psychological, social, and economic needs. Satisfactory job placement and self independence in activities of daily living within the limits of his disability will result.

H. Worley Kendall, M.D.

*A total of five years of specialized training for eligibility is required by the American Board of Physical Medicine and Rehabilitation. Physiatrist is the name given to the physician practicing this specialty.

Private Crusades

Anticipating the year 1960 as one for high incidence of poliomyelitis, the Chicago Medical Society and the State Department of Public Health have urged upon the public immunization of all susceptible individuals prior to the critical months of August, September, and October.

The state department has recommended a booster dose of vaccine for those who received their last injection of primary immunization a year ago and at yearly intervals thereafter. The Chicago Medical Society also recognizes the necessity for immunizing all persons, because, since the onset of immunization, a 4-year high incidence cycle has occurred in 1952 and 1956, and a large number of polio cases are expected for 1960.

Public education is necessary and a fine thing. It prepares the mind in general, starts discussions, conversations across tables — be they for bridge or dinner — and feeds conversations across backyard fences.

But there is another, more active phase to this campaign for immunization. We would urge each individual physician to conduct his own private crusade within his family of patients—parents and grand parents, young people—those to whom he may be called, come late summer, to administer more than drugs, if 1960 proves to be the high incidence polio year as predicted.

A word here, a warning there can be most effective. Junior may have "only a cold and a little sore throat" this month, and parents are concerned, not alarmed. But next August. . . .

The force of the written word is not to be disputed; yet it cannot transcend the power of the physician-patient relationships we build and cultivate as our pride and hold as a knight his shield. So armed, let us do personal battle with the Great Crippler ere he appears.

Statistics don't lie

Statistics are defined as facts or data of a numerical kind, assembled, classified, and tabulated to present significant information about a given subject. These data may be quite different if assembled and classified by different individuals or firms surveying selected cross sections of the population. A case in point involves apportioning the so-called medical care dollar to show how it is spent. Although there is no great difference on reporting the way this dollar is being cut up, it illustrates how such selected samples may vary.

	A	B	C	D[2]
Physicians Services	.24	.26	23.8	.34
Hospitals	.26	.31	26.4	.23
Dentists	.10	.10	10.2	.15
Drugs	.20	.27[1]	19.9	.20
Appliances	.07		...	..
Health Insurance	.08	..	8.3	..
All Others	.05	.06	11.4	.08
Total	$1.00	$1.00	$1.00	$1.00

1. Includes appliances.
2. 1957-58. All others are 1958.

A.—Source Dept. of Commerce, Office of Business Economics.

B.—Source Dept. of Commerce, and Dept. HEW.

C.—Source "What Cost Medical Care" by Jules Backman in October 1959 Journal of the American Pharmaceutical Association.

D.—Health Information Foundation survey of 2,941 families consisting of 9,546 persons; one or more per family were interviewed.

When you consider that $16.4 billion was the total amount spent for medical care in 1958, a four or five cent difference in each dollar makes a lot of difference in the total. Is there a moral to this? No, just some more figures.

George F. Lull, M.D.

Why Grandma won't learn

It is not true that you cannot teach an old dog new tricks, but the new tricks constitute an adjustment for the old dog which is difficult for him to make. Among human beings, every change calls for a readjustment, every readjustment means a new tension, and every new tension brings about a new set of neural patterns—or, if you will, an additional hardening of the arteries. All people find, sooner or later, that there is a limit to this process. One day they must resist time and its handmaiden, change, lest the world be totally unfamiliar. *Frederic W. Terrien.* Geriatrics, March, 1960.

Annual Meeting ISMS

General Assembly Programs

Wednesday Morning, May 25, 1960

The Ballroom

Presiding.....E. W. Cannady, East St. Louis
Chairman, Committee on Aging, ISMS

Opening remarks...Ruth E. Church, Springfield
Deputy Director, Division of Hospitals and Chronic Illness, Department of Public Health

9:15 a.m. SYMPOSIUM: "Minimizing the Disability Due to Stroke by Early Preventive Treatment"
Closed Circuit Television Demonstration
Michael Reese Hospital
Edward E. Gordon and Associates
Department of Physical Medicine
SPONSORING AGENTS:
Department of Public Health
Michael Reese Hospital
Committee on Aging, ISMS

Presiding ..... Joseph T. O'Neill, President
Illinois State Medical Society
10:00 a.m. THE FIRST HAROLD M. CAMP MEMORIAL LECTURE
"Surgical Patterns of Atherosclerosis"
Michael E. DeBakey, Houston, Texas
Professor, Department of Surgery
Baylor University College of Medicine

10:45 a.m. RECESS TO VIEW EXHIBITS

Presiding ..... George Byfield, Chicago
Assisting ..... Wm. DeHollander, Springfield
11:15 PANEL: "The Diagnosis and Management of Hepato-Biliary Diseases"
MODERATOR: N. Frederick Hicken, Salt Lake City, Associate Clinical Professor of Surgery, University of Utah College of Medicine
PANELISTS: Philip Thorek, Chicago
Ben Lichtenstein, Chicago
Walter L. Palmer, Chicago
Abraham I. Doktorsky, Chicago

Wednesday Afternoon, May 25

The Ballroom

Presiding ..... Joseph T. O'Neill, Ottawa
Assisting ..... Lee N. Hamm, Lincoln

1:30 p.m. ORATION IN SURGERY: "Changing Aspects of Pediatric Surgery"
Willis J. Potts, Chicago, Professor of Surgery, Northwestern University Medical School
2:00 ORATION IN MEDICINE: "The Treatment of the 'Untreatable' Patient"
Joseph B. Kirsner, Chicago, Professor of Medicine, University of Chicago School of Medicine

2:30 RECESS TO VIEW EXHIBITS

Presiding ..... Walter Maddock, Chicago
Assisting ..... Harold Kolb, St. Joseph
3:00 PANEL: "Diaphramatic Hernia"
MODERATOR: John T. Reynolds, Chicago, Clinical Associate Professor of Surgery, University of Illinois College of Medicine
PANELISTS: Lowell D. Snorf, Chicago
Raymond L. Del Fava, Chicago
Paul H. Holinger, Chicago

7:00 ANNUAL DINNER
SPEAKER: Virgil Peterson, Operating Director, Chicago Crime Commission

Thursday Afternoon, May 26

The Ballroom

Presiding ..... Wright Adams, Chicago
Assisting ..... Casper Epsteen, Chicago
1:30 p.m. "Use of Live Polio Virus Vaccine"
Herald Cox, Ph.D., Chicago

2:15 RECESS TO VIEW EXHIBITS

Presiding ..... William F. Mengert, Chicago
Assisting ..... V. P. Siegel, East St. Louis
2:45 Movie, "Examination of the Eye"
Eugene Folk, M.D.
3:30 "M.D., U.S.A.," preview of a new film

SCIENTIFIC EXHIBITS 1960

Booth 1: **A Study of Infantile Colic**

EXHIBITOR: Lawrence Breslow

INSTITUTION: Department of Pediatrics, College of Medicine University of Illinois

DESCRIPTION: A clinical classification of 165 infants with infantile colic.

Booth 2: **Cholangiography, Operative and Postoperative**

EXHIBITORS: Karl A. Meyer, Peter A. Rosi, Nicholas J. Capos, Joseph J. Litschgi

INSTITUTION: Cook County Hospital, Chicago.

DESCRIPTION: The primary purpose of this method of investigation is to visualize the biliary tree to be sure there is free flow of bile into duodenum and no common or hepatic duct stones are overlooked. May be done directly at operation with portable unit, or post-operatively through "T" tube. Stones show as negative shadows. Obstruction of the common duct due to spasm of the sphincter of Oddi, tumor of ampulla of Vater or head of pancreas, or chronic pancreatitis are revealed. Cholangiectasis from obstruction of duct or stenosis of sphincter is demonstrated.

Booth 3: **The Repair of Tissue Deficient Hernias by Aortic Implants**

EXHIBITORS: Samuel J. Fogelson and Roy G. Cooksey

INSTITUTION: Northwestern University Medical School and Cook County Hospital

DESCRIPTION: Series of colored photographs of procedures with descriptive legends.

Booth 4: **The Systemic Manifestations of Scleroderma**

EXHIBITOR: William T. Meszaros

INSTITUTION: Cook County Hospital

DESCRIPTION: Scleroderma affects many systems, usually in a characteristic manner. Knowledge of all possible manifestations is essential for precise diagnosis and evaluation.

Booth 5: **Hydatidiform Mole and Chorioepithelioma**

EXHIBITOR: Frederick H. Falls and Charlotte S. Holt

INSTITUTION: Illinois State Department of Public Health, River Forest

DESCRIPTION: The exhibit will consist of 5 panels describing normal nidation, early trophoblastic activity, and placentation and their relationship to the formation of the hydatidiform mole. The transition from these changes into those of a malignant mole and finally into choriloepithelioma will be shown along with treatment.

Booth 6: **Disorders of Hemostasis—Laboratory Diagnosis**

EXHIBITORS: Jack Lazerson and Emanuel E. Mandel

INSTITUTION: The Chicago Medical School and Mt. Sinai Hospital

DESCRIPTION: It is planned to prepare an outline of (a) routine tests for detection of a (potential or occult) hemorrhagic diathesis and (b) diagnostic steps for investigation of such a disorder when suspected or uncovered. Current concepts of the coagulation mechanism will be described. Both congenital and acquired hemorrhagic disorders will be listed. The problem of detection of the "prethrombotic" state will also be considered. Routine test procedures, such as plasma and serum prothrombin, thrombo-

plastin generation, and fibrinogen will be depicted.

Booth 7: **The Evolution of Urinalysis**

EXHIBITORS: E. M. Knights, Jr., G. M. Longfield, and R. M. Webster

INSTITUTION: Hurley Hospital, Flint, Mich.

DESCRIPTION: Exhibit shows development in the technique for studying the urinary glucose, protein, and ketones, specifically with some information on miscellaneous tests (such as blood, bilirubin, chondroitin sulphuric acid, etc.). A brochure supplements the exhibit.

Booth 8: **The Conduction System in Cardiac Surgery**

EXHIBITORS: Maurice Lev, Wm. L. Riker, Arthur DeBoer, Thomas Baffes, and W. J. Potts

INSTITUTION: Children's Memorial Hospital, Chicago

DESCRIPTION: Drawings and wax models indicate the conduction system in the normal and congenitally deformed heart. Means to avoid its damage at surgery are depicted and described.

Booth 9: **Multicentric Carcinogenesis in the Human Liver**

EXHIBITOR: Hans Elias

INSTITUTION: Chicago Medical School

DESCRIPTION: Histological observations of 84 hepatoma cases showing multiple foci in 62 per cent of cases.

Booth 10: **The Use of Choline Salicylate in Rheumatic Fever and Rheumatoid Arthritis**

EXHIBITORS: Capt. P. T. Moore and Lt. W. J. Baker

INSTITUTION: U. S. Naval Hospital, Great Lakes

DESCRIPTION: Describes the use of the newly available choline salicylate in the treatment of rheumatic fever and other arthropathies. As a water soluble preparation, it provides certain convenience in the administration of large dosages of salicylates. Patients' response to treatment is illustrated by charts and results indicate that this new drug demonstrates anti-inflammatory, analgesic and antipyretic properties comparable to those of previously known salicylates.

Booth 11: **Open Heart Surgery for Mitral Valve Disease: Advantages, Risks, Accomplishments**

EXHIBITOR: Louis R. Head, James M. Head, Theodore R. Hudson, and Jerome R. Head

INSTITUTION: Chicago Wesley Memorial Hospital and Northwestern University

DESCRIPTION: Compares open and closed methods of surgery for mitral valve disease.

Booth 12: **Physiologic Evaluation of Therapeutic Physical Agents**

EXHIBITORS: David I. Abramson, Yvonne Bell, Samuel Tuck, Jr., and Roscoe Mitchell

INSTITUTION: Department of Physical Medicine & Rehabilitation, University of Illinois College of Medicine

DESCRIPTION: The research on which the exhibit is based involved the measurement of blood flow, local tissue temperatures, and oxygen uptake in the human forearm. Among the modalities depicted are wet heat and cold, short-wave diathermy, ultrasound, mecholyl by ion-transfer and reflex vasodilatation. Graphs typifying the effects of altering tissue temperature on the oxygen debt incurred during periods of arterial occlusion and of anaerobic work are also included in the demonstration.

Booth 13: **Tranquilizers, Barbiturates and the Brain**

EXHIBITOR: Harold E. Himwich

INSTITUTION: Galesburg State Research Hospital, Galesburg, Illinois

DESCRIPTION: The sites of action of the major

tranquilizers and the barbiturates are visualized, and the influenee of these drugs on these sites are compared and contrasted not only to distinguish the effeets of the tranquilizers from those of the barbiturates, but also to make distinctions between the individual tranquilizers. The normal functions of the key areas of the brain affected by these drugs are described.

Booth 14: Pelvic Inflammatory Disease: Chymotrypsin Therapy

EXHIBITORS: Walter J. Reich and Mitchell J. Nechtow

INSTITUTION: Cook County Hospital; Chicago Medical School; Cook County Postgraduate School

DESCRIPTION: A personal report on the use of chymotrypsin therapy from investigative work done at Cook County Hospital on a series of 219 patients receiving 1,586 injections of chymotrypsin. The exhibit will discuss the present pathology, symptomology, pelvic findings, diagnosis, management, and criteria for clinieal improvement and response to chymotrypsin.

Booth 15: Leiomyoma and Leiomyosarcoma of the Gastro-intestinal Tract

EXHIBITOR: Hildegarde Schorsch and Hyo Hyun Byun

INSTITUTION: Cook County Hospital and Stritch School of Medicine, Loyola University

DESCRIPTION: Clinical and roentgen manifestations of leiomyoma and leiomyosarcoma of gastro-intestinal tract.

Booth 16: Sunlight and the Skin

EXHIBITOR: Veronica L. Conley

INSTITUTION: American Medical Association Committee on Cosmetics

DESCRIPTION: This exhibit describes the physical exposure factors and the physiologic and pathologic reactions to the sun's rays. Illustrations include conditions caused, provoked and aggravated by the ultra violet rays.

Booth 17: Pancreatitis Acute and Chronic

EXHIBITORS: John M. Coleman, Arkell M. Vaughn, Vincent Staunton, and Antonine L. Skapars

INSTITUTION: Mercy Hospital; Stritch School of Medicine of Loyola University; and Vaughn Medical Group, Chicago

DESCRIPTION: The exhibit covers physiology, anatomy and classification of pancreatitis. It further describes the complications and diagnostic laboratory procedure and shows figures of x-ray abnormalities; both medical and surgieal treatment are discussed, diagrammed.

Booth 18: Full-Time County Health Departments in Illinois

EXHIBITOR: Harold K. Fuller, Executive Secretary

INSTITUTION: Illinois State-Wide Public Health Committee, Springfield

DESCRIPTION: Through the use of promotional materials the exhibit shows the services of a full-time county health department.

Booth 19: Effective Control of "Toxemia"

EXHIBITOR: H. E. Schmitz, Miehael P. MacLaverty and Robert S. Pavlic

INSTITUTION: Loyola University Stritch School of Medicine

DESCRIPTION: The exhibit consists of a critical statistical evaluation of apparently effective therapy employed at Lewis Memorial Maternity Hospital in the management of over 400 patients with "toxemia" of pregnancy. This includes an outline and explanation of eurrent management.

Booth 20: The Crico-Arytenoid Joint

EXHIBITOR: Hans von Leden and Paul Moore

INSTITUTION: Northwestern University and the William and Harriet Gould Foundation

DESCRIPTION: The traditional concept of arytenoid motion requires modifications as the result of recent anatomical, cinematographic and mathematical studies. Motion of the principal laryngeal joint is governed by the configuration of the two opposing articular surfaces. Photographs and photomicrographs portray the anatomic details of the cricoarytenoid motion. Animated scale models demonstrate the principal components of motion. Ultra-slow motion pictures demonstrate the mechanics of the crico-arytenoid joint in man.

Booth 21: Diuretic Therapy and Salt Liberalization in Heart Failure

EXHIBITOR: Morton Fuchs, Benjamin Newman, Sanford R. Mallin, and John H. Moyer

DESCRIPTION: Hahnemann Medical College and Hospital Philadelphia

INSTITUTION: Sodium and water retention is the focal point of the pathophysiological influences in congestive heart failure. Drug therapy of heart failure is aimed at increasing myocardial efficiency and decreasing renal tubular sodium reabsorption.

Booth 22: Dysmenorrhea, Cramps or Psyche?

EXHIBITOR: Dennis M. Voulgaris

INSTITUTION: Gulf Coast Medical Foundation; Rugeley and Blasingame Clinic and Hospital, Wharton, Texas

DESCRIPTION: This exhibit presents the history and subject of dysmenorrhea as well as the review of accepted medical and surgical methods of management. It involves the presentation of a new concept based on the principle of uterine musculature relaxation.

Booth 23: The Work of the Doctor Portrayed through Sculpture

EXHIBITOR: Frederick Stenn and Eugene Friduss

INSTITUTION: Northwestern University Medical School

DESCRIPTION: Life-sized sculptured pieces done in wrought iron representing the doctor in his efforts to conquer disease, with appropriate quotations from the great doctors of the past.

Booth 24: Routine Examination for Cancer Detection

EXHIBITOR: F. Lee Stone and Caesar Portes

INSTITUTION: Cancer Prevention Center of Chicago, Inc.

DESCRIPTION: The exhibit emphasizes that *early* detection of cancer and precancerous conditions is important in cancer control and demonstrates what each doctor can do to detect early cancer in his own office. Exhibit includes color drawings illustrating various phases of the examination, two moulages of polyps and carcinoma of the rectum, kodachrome transparencies of Papanicolaou stains and x-rays of the colon and lungs.

Booth 25: Experiences with a New Organic Cellulose Powder: Use in 2,252 Cases.

EXHIBITOR: Cleveland J. White

INSTITUTION: Stritch School of Medicine, Loyola University

DESCRIPTION: This new organic absorbent maize cellulose powder has now been used in a large number of cases. Its indications, use and results will be delineated.

Booth 26: Cancer of the Head and Neck

EXHIBITOR: John A. Rogers

INSTITUTION: American Cancer Society, Illinois Division, Inc., Chicago

DESCRIPTION: The left-hand panel emphasizes the importance of properly dealing with the lump in the neck. The center panel portrays examination of lips, oral cavity, pharynx and larynx and exhibits typical lesions of these areas. The

right-hand panel deals with biopsy techniques.

Booth 27: Medical Pathfinders on Postage Stamps

EXHIBITOR: John A. Mirt, Clara Mai Rutherford

INSTITUTION: Illinois State Medical Society

DESCRIPTION: An illustrated narration with postage stamps of the world showing progress of medicine from the days of Imhotep through those of Hippocrates, Maimonides, and the medieval years to the present. Stamps include those bearing portraits of physicians who have made noteworthy contributions to medicine, others depicting health care. The central figure is "The Doctor" stamp issued to commemorate the centenary of the AMA.

Booth 28: Clearing House Program of the American Association of Blood Banks

EXHIBITORS: Welland A. Hause, Ardyth Z. Cobb, and William S. Kyler

INSTITUTION: Illinois Association of Blood Banks and North Central District Clearing House, Chicago

DESCRIPTION: Illustrates importance of the Clearing House Program to physicians and blood banks in Illinois.

Booth 29: Group Practice Survey

EXHIBITOR: George W. Cooley

INSTITUTION: American Medical Association, Council on Medical Service; and American Association of Medical Clinics, National Association of Clinic Managers, Chicago

DESCRIPTION: The exhibit pinpoints on a map the location by size of 1,100 group practices developed in a recent survey by the Council on Medical Service of the AMA. It also affords information on the professional aspects of group practice, illustrates the rapid growth of clinics, and describes some considerations on the business side of group practice.

Booth 30: Today's Quotation "Rehabilitation Pays 10 to 1 Dividend"

EXHIBITOR: E. C. Cline

INSTITUTION: Illinois Division of Vocational Rehabilitation and Rehabilitation Institute of Chicago

DESCRIPTION: Educational exhibit to acquaint the medical profession with services and cooperation of the Division and the Rehabilitation Institute of Chicago.

Booth 31: When Does Your Rx Become a Poison?

EXHIBITOR: N. J. Rose

INSTITUTION: Illinois Department of Public Health, Bureau of Hazardous Substances and Poison Control, Springfield

DESCRIPTION: Shows photographically dangers of physician's Rx in the hands of children, and the proper labeling of hazardous substances.

1960 Technical Exhibits

63 Abbott Laboratories
North Chicago, Illinois

2 Audio-Digest Foundation
Glendale, California

45 The Baker Laboratories, Inc.
Cleveland, Ohio

36 Blue Shield Plan of Medical-Surgical Service of Illinois
Rockford, Illinois

56 The Book House for Children
Lake Bluff, Illinois

76 Boreherdt Company
Chicago, Illinois

41 Bristol Laboratories, N'
New York, New York
10 Brooks Appliance Company
Chicago, Illinois
67 Chicago Pharmacal Co.
Chicago, Illinois
72 Ciba Pharmaceutical Products Inc.
Summit, New Jersey
14 The Coca Cola Company
Atlanta, Georgia
15, 16, 17 Daniels Surgical & Medical Supplies
Chicago, Illinois
30 Desitin Chemical Company
Providence, Rhode Island
65 Diamond Laboratories Co.
Des Moines, Iowa
4 The Dietene Company
Minneapolis, Minnesota
37 Doho Chemical Corp.
New York, New York
6 Eaton Laboratories
Norwich, New York
46 Eisele & Company
Nashville, Tennessee
70 Eli Lilly and Company
Indianapolis, Indiana
29 Encyclopaedia Britannica
Chicago, Illinois
61 62 Marshall Erdman & Associates, Inc.
Madison, Wisconsin
77 Geigy Pharmaceuticals
Yonkers, New York
54 The G. F. Harvey Company, Inc.
New York, New York
26 Illinois Medical Service
Chicago, Illinois
34 Jackson-Mitchell Pharmaceuticals
Culver City, California
9 Johnson & Johnson
New Brunswick, New Jersey
28 Kidder, Peabody & Company
Chicago, Illinois
13 Lederle Laboratories
Pearl River, New York
59 J. B. Lippincott Company
Philadelphia 5, Pa.
39 Lloyd Brothers, Inc.
Cincinnati, Ohio
24 Loma Linda Food Company
Arlington, California
11 P. Lorillard Company
New York, New York
55 Marion Laboratories, Inc.
Kansas City, Missouri
33 Massachusetts Indemnity & Life Insurance Company
Boston, Massachusetts
8 The S. E. Massengill Company
Kansas City, Missouri
66 Medco Products Company
Tulsa, Oklahoma
12 Medical Arts Supply Company
Chicago, Illinois
7 Medical Management
Chicago, Illinois
73 The Medical Protective Company
Fort Wayne, Indiana
19 Merck Sharp & Dohme
Philadelphia, Pa.
58 V. Mueller & Company
Chicago, Illinois
78 Parke, Davis & Company
Detroit, Michigan
47 Parker, Aleshire & Company
Chicago, Illinois
57 Pepsi-Cola General Bottlers, Inc.
Chicago, Illinois
71 Pet Milk Sales Corporation
St. Louis, Missouri
21 Pfizer Laboratories
Brooklyn, New York
20 Pharmacia Laboratories, Inc.
Rochester, Minnesota
38 Professional Life & Casualty Co.
Chicago, Illinois
68 The Purdue Frederick Company
New York, New York
3 Rasman Pharmacal Company
Oak Park, Illinois
32 R. J. Reynolds Tobacco Company
Winston-Salem, North Carolina
18 A. H. Robins Company, Inc.
Richmond, Virginia
31 Roche Laboratories
Nutley, New Jersey
22 J. B. Roerig & Company
New York, New York
64 Sanborn Company
Waltham, Massachusetts
69 W. B. Saunders Company
Philadelphia, Pa.
35 Julius Schmid, Inc.
New York, New York

79 G. D. Searle & Co.
Chicago, Illinois

1 7-Up Developers' Association
of Illinois
Chicago, Illinois

25 Smith Kline & French Laboratories
Philadelphia, Pa.

76 E. R. Squibb & Sons
New York, New York

27 Standard Process Laboratories
Vitamin Products Company
Chicago, Illinois

75 R. J. Strasenburgh Company
Rochester, New York

23 United States Tobacco Company
New York, New York

74 The Upjohn Company
Kalamazoo, Michigan

5 Winthrop Laboratories
New York, New York

Schedule of Motion Pictures

The following moving pictures will be shown each day of the annual meeting. One minute is allowed between pictures.

8:45 No Margin for Error

Black and white, sound, 30 minutes (1959)

Produced in cooperation with the American Medical Association and the American Hospital Association

Procurable from: Motion Picture Library, American Medical Association, 535 North Dearborn Street, Chicago 10.

Abstract: Presents one of the most pressing current problems in legal medicine, the cause and effect of human mistakes in the complex system of the modern hospital. Case histories deal with major causes of in-hospital professional liability action. Mix-up in patient identification, mistakes in blood bank procedure, and error in medication dosage are examples of problems the film reveals.

9:16 The Epidemiology of Staphylococcal Infections

Color, sound, 13 minutes (1958)

Procurable from: Communicable Disease Center, Chamblee, Ga.

Abstract: Demonstrates the complex transmission patterns resulting from the interaction of the etiologic agent, the reservoir, the host, and the environment. In hospitals the principal reservoirs are nasal carriers among hospital personnel. These may transmit the staphylococcal organisms directly to patients, or indirectly by contaminating the hospital environment. Reviewed in JAMA October 17, 1959, page 1030.

9:30 Prevention and Control of Staphylococcal Infections

Black and white, sound, 17 minutes (1958)

Procurable from: Communicable Disease Center, Chamblee, Ga.

Abstract: An analysis of staphylococcal infections in hospitals is presented. Aseptic techniques and improved housekeeping procedures are emphasized as control measures. Reviewed in JAMA October 17, 1959, page 1030.

9:48 Mouth to Mouth Resuscitation for Respiratory Emergencies

Color, sound, 18 minutes (1958)

Prepared by: Archer S. Gordon, M.D., Los Angeles

Procurable from: Archer S. Gordon, M.D., 4614 Sunset Boulevard, Los Angeles.

Abstract: The film details the physiologic requirements for effective artificial respiration and outlines the experimental and practical background of the development of mouth to mouth resuscitation. Regular and slow motion views depict the preferred techniques for mouth to mouth and mouth to nose resuscitation for children and adults. Reviewed in JAMA October 31, 1959, page 1253.

10:07 Physical Diagnosis—The Larynx
Color, sound, 14 minutes (1959)
Prepared by: Frederick J. Margolis, M.D., and Paul H. Holinger, M.D., Chicago
Procurable from: Ciba Pharmaceutical Products, Summit, N.J.
Abstract: Covers organic diseases of the larynx with methods of diagnosis and the endoscopic picture of the pathology.

10:22 Physical Examination of the Newborn—The Art and Findings
Color, sound, 33 minutes (1959)
Prepared by: Mary B. Olney, M.D., San Francisco
Procurable from: Pfizer Laboratories, Division of Chas. Pfizer, Inc., Brooklyn 6, N.Y.
Abstract: Part I of the film demonstrates the steps of a complete routine examination as it is performed for a baby a few hours old. Part II shows special examination techniques and some of the more common abnormal findings, as well as normal findings which can be mistaken for anomalies.

10:56 Physical Diagnosis—Disorders of Motility
Color, sound, 32 minutes (1959)
Prepared by: Frederick J. Margolis, M.D., and A. M. Ornsteen, M.D., Philadelphia
Procurable from: Ciba Pharmaceutical Products, Summit, N.J.
Abstract: Twenty-nine patients with characteristic neurological gait disorders covering everything from muscular dystrophy and brain tumor in children to the paretic gait of syphilis are discussed and described. Not only are advanced and severe gait disorders shown, but many of the cases demonstrate the early diagnostic signs.

11:29 Physical Diagnosis—The Ear and Hearing
Color, sound, 20 minutes (1959)
Prepared by: Frederick J. Margolis, M.D., Kalamazoo, and George E. Shambaugh, M.D., Chicago
Procurable from: Ciba Pharmaceutical Products, Summit, N. J.
Abstract: This film shows the basic anatomy of the ear followed by a series of patients demonstrating the diagnosis of different types of deafness, the effects of deafness on speech, disorders of the external ear and canal, diseases of the drum, and examples of different facial nerve branch paralyses.

11:50 Management of Breast Feeding
Black and white, sound, 13 minutes (1959)
Prepared by: Gordon D. Jensen, M.D., Seattle
Procurable from: Film Center, University of Washington, Seattle 5
Abstract: Shows some of the problems most frequently encountered in breast feeding and some of the important techniques by which the nursing mother can be assisted.

12:05 Lunch

2:00 A Matter of Fact
Black and white, sound, 26 minutes (1959)
Procurable from: Motion Picture Library, American Medical Association, 535 North Dearborn Street, Chicago 10
Abstract: This film deals with the subject of forensic pathology and more specifically demonstrates the value of pathologists who are trained in medical-legal investigation.

2:27 A Complete Office Gynecological Examination
Color, sound, 16 minutes (1958)
Prepared by: F. J. Hofmeister, M.D., Milwaukee
Procurable from: F. J. Hofmeister, M.D., 2212 West State St., Milwaukee, Wis.
Abstract: Demonstrates the author's conception of an adequate, office gynecological examination. The author is primarily stressing the importance of considering the entire woman with particular emphasis on the complete gynecological examination. Demonstrations of a method of obtaining material for Papanicolaou smears, endometrial biopsies, and cervical biopsies are included. Reviewed in JAMA April 4, 1959, page 1661.

2:44 Management of Burns
Color, sound (1959)
Procurable from: Armed Forces Institute of Pathology, Washington 25, D. C.
Part I: *Supportive Care*—17 *minutes.* Covers the diagnosis, care, and treatment of patients suffering from burn injuries, pointing out that early supportive care is vital for recovery.

3:02 *Part II: Local Care—15 minutes.* Discusses the local care of burned patients, covering the procedures followed in the dressing and operating rooms. Emphasis is placed upon the importance of preventing contamination of the wound, and changing dressings at regular intervals.

3:18 Open Fractures

Color, sound, 23 minutes (1959)

Prepared by: William Larmon, M.D., Chicago

Procurable from Veterans Administration, Central Office Film Library, Washington 25, D. C.

Abstract: The film begins with an open fracture of the tibia occurring in the street. The emergency on-the-spot treatment is shown as well as the treatment in the emergency room. Definitive surgery is carried out in the operating room in two types of cases, one treated by the open method and one treated by primary closure. Principles of treatment of open fractures are stressed with animation and actual surgery.

3:42 Femoral Hernia With Necrotic Ileum

Prepared by: Clarence Dennis, Brooklyn, N.Y.

Procurable from: Surgical Film Library, American Cyanamid Company, 1 Casper Street, Danbury, Conn.

Abstract: The mortality of strangulated femoral hernia with necrotic bowel in it remains high in spite of antibiotics. The division of the inguinal ligament to permit removal of the sac intact, coupled with aseptic anastomosis of the ileum, permits repair in a clean field and marked reduction of mortality and morbidity.

4:13 Inguinal Herniopiasty

Prepared by: Chester B. McVay, Yankton, S. D.

Procurable from: Surgical Film Library, American Cyanamid Company, 1 Casper Street, Danbury, Conn.

Abstract: The important steps in the repair of three inguinal hernias are presented illustrating the author's methods of repairing these hernias. For this purpose, two small indirect and one large direct inguinal hernia have been selected. The details of "Abdominal Ring Repair" and "Reconstruction of the Posterior Inguinal Wall" are also presented.

Alternates

Cerebral Vascular Disease—The Challenge of Management

Black and white, sound, 38 Minutes (1959)

Procurable from: American Heart Association Film Library, 267 W. 25 Street, N. Y.

Abstract: Acquaints general practitioners and nurses with techniques and concepts basic to the management of persons who have suffered "strokes" or who have experienced the more obvious premonitory signs.

Cancer of the Stomach Gastrectomy

Color, sound, 39 minutes (1958)

Prepared by: William H. ReMine, M.D., and Waltman Walters, M.D., Rochester, Minn.

Procurable from: Section of Photography, The Mayo Clinic, Rochester, Minn.

Abstract: Radical subtotal partial gastrectomy and radical total gastrectomy are shown. Charts indicate lowered mortality rates and prolonged survival rates in a recent series of cases as compared with a similar series operated on prior to 1939.

March Council Meeting

The regular meeting of the Council was called to order by the chairman at 9:20 a.m. Sunday, March 13, 1960, at the Hotel Sherman, Chicago with the following present: O'Neill, Hesseltine, Hamm, Burdick, Clark, Redmond, Adams, Reichert, Montgomery, Portes, Piszczek, Dooley, Blair, Endres, Reisch, DuPuy, Goodyear, English, Fullerton, Klein, Limarzi, Sheehe, Lorne Mason, Lull, Hamilton, Brislen, Hopkins, White, Bornemeier, Van Dellen, Nicholson, Mirt, Neal, Oblinger, and Frances Zimmer.

Dr. Montgomery reported that the Executive Committee, as authorized by Council action, had employed Robert L. Richards, formerly with the Medical Society of the State of Pennsylvania, and now employed by the American Society of Internal Medicine in San Francisco.

Dr. Hopkins, chairman of the Ad Hoc Committee (on personnel and job specifications), said the committee had been charged with the responsibility of securing an administrator and an assistant, a public relations director, etc. The Executive Committee had interviewed two men, who were presented before the meeting proper began: Mr. D. L. Martin, public relations director for the Illinois Bar Association, and another applicant. Both were recommended by Conley and Associates, the firm employed by the Ad Hoc Committee to conduct the search for new employees and to develop the job specifications for the ISMS.

The Ad Hoc committee reported that after consultation with Mr. Richards, they recommended that Mr. Martin be employed as director of public relations and field services to begin July 1; also that the other applicant, who has an M.A. degree from Iowa and another from Indiana and has been working on his Ph.D. degree from Syracuse University, be employed as director of scientific activities and publications. He can begin before July 1.

Dr. Montgomery stated that the Executive Committee recommends that the Council employ the two men and that they be offered a suitable contract.

MOTION: (Fullerton-Piszczek) that the recommendations of the Executive Committee in regard to a contract for the two men be approved. (Motion carried.)

Dr. Hopkins stated that Mr. Richards would be responsible to the Chairman of the Council and the new employees would be responsible to Mr. Richards.

MOTION: (Fullerton-Piszczek) that the employment of Mr. Richards be approved. (Motion carried.)

MOTION: (Hesseltine-Adams) that the Council thank the committee for its work. (Motion carried.)

MOTION: (Fullerton-Piszczek) that the minutes of the January 31 meeting be approved as corrected. (Motion carried.)

Report of President

Dr. O'Neill reported as president. He has been receiving many letters as a result of the Blue Shield contract for people over 65. Perhaps some of this difficulty resulted from the lateness of the

publication of the minutes of the December meeting of the House of Delegates, which are scheduled to appear in the March issue of the Illinois Medical Journal.

Dr. O'Neill has concerned himself seriously with the importance of postgraduate education. He was impressed very much by an article which appeared in Postgraduate Medicine for January. The program which the Michigan State Medical Society has developed is outstanding. The fact that Illinois is losing graduates because of the dearth of residencies in this state was called to the attention of the Council at a recent meeting. Michigan has developed a program with the cooperation of the University of Michigan. Dr. O'Neill had enough reprints for each Councilor and hoped that such a program could be considered in Illinois. Naturally each president of the Society would like to make some contribution to the welfare and betterment of the medical profession during his term of office. Since Dr. O'Neill's interest is in the field of postgraduate education for physicians, he would like to have an expression of opinion from the Council after its members have had an opportunity to read the material distributed, with subsequent action at the April meeting.

MOTION: (Fullerton-Piszczek) that the report be accepted. (Motion carried.)

Dr. Hesseltine had no report as president elect. As chairman of the finance committee, he reported a meeting with the auditor, Mr. Fred Setterdahl of Rock Island (who has audited the Society books for many years). It is the opinion of the committee that we should have a good financial presentation for the House of Delegates.

MOTION: (Klein-Fullerton) that the report be accepted. (Motion carried.)

Report of Secretary

Dr. Lull reported that space had been secured for Mr. Mirt's exhibit at the Miami meeting. The exhibit in Kewanee was viewed by some 11,000 people. The local Kiwanis Club sponsored it.

He called attention of the Council to a letter from Dr. Ruth Church, deputy director of the department of public health, which enclosed a questionnaire being sent out by Senator Pat McNamara through state health departments to be filled in by the local health departments. It is the opinion of many that new legislation will be based upon information secured through this questionnaire.

Dr. Lull reported that most of the material for the Handbook had been received for publication in the April issue of the Journal. The deadline on these reports should have been set for March 1 so that the material could have been turned over to the printer on March 10, but most of the councilors, officers, and committee chairmen have submitted their manuscripts.

The North Central Blood Bank Clearing House has paid the last $2,000 due on their loan, and the indebtedness is completely discharged.

The AMEF has thanked the Society for $10,-860 over and above the $20 per capita given by members.

MOTION: (Hesseltine-Fullerton) that the report be accepted. (Motion carried.)

Dr. Montgomery read a leter received from one of the members of the "over 65" committee, and also his reply. The matter was discussed in detail.

MS and PR

Dr. Hamilton reported as chairman of the Committee on Medical Service and Public Relations. He told of the mailings to members, the concentrated efforts on the part of the attorneys and the members of the committee. The meeting in Chicago on February 28 was not considered too successful nor the attendance too good, especially in view of the excellent program developed and the work on the part of Mr. Oblinger and Mr. Mirt. The time to press the educational program for the laity is obviously at hand—in women's clubs, Farm Bureaus, service clubs, etc., and all physicians should accept speaking engagements and do all possible to assure letters being sent to congressmen.

Mr. Oblinger stated that special work was being conducted in certain congressional districts; that mail should be sent this week to Washington; that if the Forand Bill were not contained in committee, it could well become enacted into the Social Security Act. The Sangamon Auxiliary (Mrs. Darrell Trumpe) has done outstanding work developing a "telephone tree," holding coffees, etc. The local dental group should be contacted. All physicians making calls at nursing homes should discuss this situation and see if letters from this group can be added. To date only 11 county medical societies have passed resolutions.

John Neal stated that he had talked to the Association of Club Presidents—about 400 people—and has received requests for four more appearances before service clubs, etc.

MOTION: (Fullerton-Piszczek) that the report be accepted. (Motion carried.)

Dr. Fatherree called the attention of the Council to the importance of local government in this situation, and the importance of discussing the problem with local township supervisors, etc., since the whole problem is a part of the political structure, and would affect the local control of any assistance program.

New office

Dr. Lull stated that the committee to plan for the new office would meet on Wednesday afternoon, March 16. The architects are working on the structural changes. The lease is ready for signing, subject to Mr. Neal's recommendations.

IPAC report

Dr. Compton reported as chairman of the Advisory Committee to the IPAC. As a matter of information, in the past it has been the policy of the IPAC, when some physician gets into difficulty, to call him before the state society committee and discuss the problem before action is taken. In the past month, two physicians and two pharmacists have been suspended before the state society committee was consulted. It is our opinion that this is the pattern which will be followed in the future. The hearings will be held after the suspension has taken place. Dr. English called the attention of the Council to the fact that these cases referred to in the report involved fraud.

MOTION: (Fullerton-Klein) that the report be accepted. (Motion carried.)

Annual meeting

Dr. Lorne Mason reported as chairman of the Programming Committee for the annual meeting. DeBakey will deliver the first Harold M. Camp lecture before the General Assembly on Wednesday, May 25. The preliminary program will be published in the Journal. We have been able to interest the Department of Public Health and the Academy of General Practice in helping us develop a program on "Minimizing Disability due to Stroke by Early Preventive Treatment." This group will be assisted by the Michael Reese Hospital, and closed circuit television demonstrations will be given. The Committee on Aging of the ISMS has assisted. Dr. Coye C. Mason has had charge of the scientific exhibits and movies again this year. The committee will meet again this month, probably on March 24, to make final arrangements for the scientific program.

Dr. Brislen reported that all the local committees have been appointed and will function.

Constitution and By-Laws

Dr. Walter C. Bornemeier reported that the Committee on Constitution and By-Laws had met Saturday to develop the changes suggested by the House in session last December. This material will be mimeographed, sent to the members of the Council. Definite opinions are requested so that all can be unified and presented correctly at the May meeting. This will be discussed at the April 24 meeting of the Council.

MOTION: (Portes-Adams) that the report be accepted. (Motion carried.)

Benevolence

Dr. Sheehe as chairman of the Committee on Medical Benevolence, reported that the committee recommended discontinuing the use of the National Credit Company for the investigation of the various cases. He felt that members of the Council, local county medical society officers, and members of the committee itself could secure more accurate information. Mr. Oblinger stated that he would be glad to assist in this work as soon as his time could be made available to the committee. The committee recommended that it be handled this way in the future.

MOTION: (English-O'Neill) so move. (Motion carried.)

Dr. Sheehe reported 22 physicians and 22 widows receiving assistance from the Benevolence Fund at this time.

Postgraduate and Scientific Service

Dr. Limarzi stated that the meeting at Springfield was fairly well attended considering the weather. The Mattoon meeting is scheduled for April 7; the only other meeting set is in LaSalle for April 28. Loyola will present the Mattoon program and Chicago Medical School the LaSalle program.

Dr. Brislen asked why the Springfield postgraduate meeting was scheduled during the CMS

Clinical Conference. Dr. Reisch replied that this was the regular meeting date of the Sangamon County Medical Society, and that it was the only logical date for the conference.

School Health

Dr. Fullerton reported that the Committee on School Health met on January 30 to discuss the recommendations of the previous meeting held last October. The representative of the ISMS had attempted to introduce the problem of contact sports in elementary and secondary schools before the Joint Committee on School Health in Illinois at its recent meeting. However, it was not successful. It is hoped that the material can be introduced in the near future. The Society committee recommended that we "wait and see what recommendations develop at the 1960 White House Conference on Children and Youth."

Illinois is in an excellent position in this respect since Dr. Ralph Kunstadter is chairman of the Sub-Committee on Health, and he reflects the thinking of the Illinois Chapter of the American Academy of Pediatrics and the state society committee in regard to contact sports.

The committee felt that no action should be taken at this time regarding accident and health insurance in elementary and secondary schools, and we should await the final outcome of the "Monitor Case."

It was recommended by Dr. Reichert and Dr. Kunstadter that the ISMS recommend that funds be made available for the implementation of the amended school law, House Bill #30, and that these funds be extended for remedial care for children examined as prescribed under the law. The committee recommends that the Council refer this matter to our legal counsel and also to our legislative committee for study.

Motion: (Fullerton-Klein) so move.

Dr. Reichert discussed this proposed activity and went into more detail. Children are examined under the school code every four years; this is compulsory. These examinations are made by the family physician, or in cases where there is financial hardship, this becomes the responsibility of the Department of Public Health, or its agents. The question of making funds available to provide remedial care is important. The examinations should be followed by an educational program by the family physician, and by the public agency handling the cases referred to it. The "care program" should be encouraged in the existing clinics; the medical profession itself can do no more than aid and abet the principle that following examinations, existing conditions should be corrected. We have no thought in mind to extend care, but simply to encourage the use of existing facilities on the same basis set up at this time. The examinations, required by law, should be made meaningful.

Dr. Reichert suggested that the motion be amended to state that the Council approved the principle of remedial care following the examinations in these cases. The amendment was seconded and passed.

The original motion was called for (that the matter be referred to the legal counsel and also to the Committee on Medical Service, for study. (Motion carried.)

Rural Health

Dr. English reported that Dr. Harry Gibbs had attended the AMA national meeting on Rural Health held in Grand Rapids. This is the last to be held; in the future regional sessions will be sponsored.

The Committee on Rural Health has been forced to take a "dim" view on the future of our student loan fund. We have some 30 applicants for assistance; we will recommend ten. The students do not seem to want to return to small towns after they have completed their medical education. The fund does not need additional money at this time and should be a "revolving" fund in the near future with about two or three annual loans. We will recommend ten applicants per year; about June 1, we may need $7,500.

The HIA program is well established and is making excellent progress.

The report was approved by Council action.

WTTW—$1,000

Dr. Hesseltine reported that the Executive Committee met Saturday and as chairman of the finance committee, he would report that they recommended contributing another $1,000 to WTTW, Channel 11, in Chicago.

Motion: (Reichert-Portes) that the $1,000 to WTTW be authorized. (Motion carried.)

Student AMA

Dr. Hesseltine stated that $1,000 has been given for the five delegates from the SAMA to

attend their meeting in Los Angeles next May; they now request an additional $1,000 for their alternate delegates to attend, since the C.M.S. didn't contribute this year. They have done so in the past and feel that as members of the ISMS this should not be duplicated at the county level. The executive committee recommends that an additional $1,000 be made available so that the alternates from the five Chicago schools may attend.

MOTION: (Hesseltine-Fullerton) so move. (Motion carried.)

$100 for National Association

Dr. Hesseltine reported that the Executive Committee also recommended that we contribute $100 to the National Association for Medical Research.

MOTION: (Hesseltine-Dooley) so move. (Motion carried.)

$75 for Conference of Presidents

Dr. Lull reported that the $75 dues for the ISMS membership in the Conference of Presidents was due and should be paid at this time.

MOTION: (O'Neill-Hesseltine) that the dues be paid. (Motion carried.)

Women M.D.'s Breakfast

Dr. Lull reported that the women physicians have requested a luncheon at the time of the annual meeting rather than the usual complimentary breakfast. As a matter of information, this breakfast was established at the time the Society held a "stag" Tuesday nights. For some reason, the breakfast has never been discontinued following the abandonment of the Tuesday stag. The Executive Committee recommended that the breakfast could be continued this year if the women physicians so desire.

MOTION: (English-Fullerton) that the Council support the recommendation of the Executive Committee. (Motion carried.)

Dr. Lull stated that the Illinois Hospital Association has asked that the ISMS co-sponsor a cocktail party at the joint meeting on April 3. The executive committee did not approve this.

MOTION: (English-Goodyear) that the Council support the recommendation of the Executive Committee. (Motion carried.)

Dr. Hesseltine reported receiving a letter from Dr. O. S. Walters, director of health services at the University of Illinois, expressing appreciation for the time and effort expended by Dr. Harlan English as councilor helping the University Health Service and the Champaign County Medical Society establish a congenial relationship and excellent working arrangements for the care of students in McKinley Hospital.

Director Public Health

Dr. Fatherree reported as director of the Department of Public Health. The regional officers have been requested to contribute professional training in the School of Optometry. It is the thinking of the department that this request should not be accepted, since teaching is not one of the fields in which the staff members of the State Department of Public Health are engaged.

MOTION: (English-Goodyear) that the Council support the director of the Department of Public Health in this decision, and that we recognize that personnel is not available for this educational program. (Motion carried.)

Dr. Fatherree reported an inquiry from a hospital in Michigan relative to the practice of medicine and surgery in Illinois hospitals by osteopaths, and an outline of the situation as it exists today. Dr. Hamilton suggested that a copy of the Medical Practice Act be sent to this hospital administrator, and that he be referred to the Department of Registration and Education for any additional information. Dr. English also suggested he be referred to the Illinois Hospital Association for staff rules and regulations.

Dr. Lull presented the inquiry from Dr. Norbury relative to listing the ISMS as one of the "sponsoring or approving" agencies for the forthcoming bond issue requested by the Department of Public Welfare. The opinion of the Council was that this issue had been approved by official action, and no additional motion was necessary to effect this listing.

Treatment of drug addicts

Dr. Lull reported that he had received a letter from Mr. George M. Belk, district supervisor, Treasury Department, Bureau of Narcotics, asking for Society action relative to the treatment of narcotic drug addicts under the so-called ambulatory clinic plan. This plan has been disapproved by the AMA and is not approved by the Bureau of Narcotics itself. Support for this stand is needed.

Motion: (Piszczek-Klein) that the matter be referred to the ISMS Committee on Narcotics, Jacob E. Reisch, chairman. (Motion carried.)

Dr. Lull reported a letter from Senator Paul Douglas relative to his stand on the Forand Bill. It is to be turned over to the office for filing.

AMA insurance meeting

Dr. Lull received a leter from J. Lafe Ludwig, M.D., the chairman of the AMA Council on Medical Service, requesting three representatives from the society to attend an invitational congress to be held at the Drake Hotel, Chicago, May 13-14.

Motion: (English-Piszczek) that the chairman appoint representatives. (Motion carried.)

Dr. Montgomery announced that he would suggest that the three members of the ISMS Constitutional Committee on Prepayment Plans be sent as the official representatives of the Society. (E. Lee Strohl, Harry E. Mantz, and Maurice M. Hoeltgen.)

Committee on Aging

Dr. Lull stated that Dr. Cannady, as chairman of the society Committee on Aging, attended a preliminary meeting in Chicago on March 8 relative to the White House Conference on Aging. He said that it was decided to have county meetings in April called by the IPAC. These meetings will be open sessions, and anything can be discussed. In May there will be six regional meetings—geographically corresponding to the IPAC regions. These will be followed by a state meeting in Springfield from which recommendations go to Washington.

The regional and state meetings will be "by invitation." Of the various committees to be appointed, one is "Committee on Physical and Mental Health," and Dr. Cannady would like suggestions. Dr. Compton stated that there was an excellent opportunity and it is advisable to have physicians appointed on the local welfare committees, where these county meetings will be planned. As a rule, there is a vacancy. The county board of supervisors appoints these committees. All he had to do in St. Clair County was to request such an appointment and the action was taken. The local committee will welcome a physician member.

The suggested names for Dr. Cannady were:

Everett P. Coleman, Canton
James W. Compton, East St. Louis
Fred A. Tworoger, Chicago
William Whiting, Anna
E. Lee Strohl, Chicago

Casualty insurance

Dr. Lull reported that he had secured the proposed casualty insurance for officers and employees with the American Casualty Company through Parker, Aleshire and Company. The principal sum is $25,000 and the annual premium is $200. This covers officers and councilors, and employees "on official business."

Motion: (English-Klein) that the purchase of the coverage be approved. (Motion carried.)

Interprofessional Council

Dr. Piszczek said that as chairman of the Committee to Study the Interprofessional Council, he and his committee would recommend that the society rejoin the organization, provided that no bills be lobbied unless they meet with the unanimous approval of all six organizations (veterinarians, dentists, pharmacists, optometrists, chiropodists) and that the Constitution and By-Laws contain such a provision.

Motion: (English-Piszczek) that the committee be authorized to communicate with the Interprofessional Council and rejoin the organization if these conditions are met. (Motion carried.)

Dr. Dooley reported that Dr. Raleigh C. Oldfield was a patient in West Suburban Hospital.

Motion: (Piszczek-Fullerton) that the secretary be instructed to send him a note and flowers. (Motion carried.)

Birth Certificates

Dr. DuPuy reported as chairman of the Committee on Birth Certificates. He had received a letter from E. L. Wittenborn, assistant deputy director, Division of General Administration, Department of Public Health; in this letter of last February 26, he had inquired about the possible desirability of including the attending physician's Illinois license number on certificates of births, stillbirths and deaths. He was not implying that the Department was actively seeking to do this, but was stating that the De-

partment was willing to amend the certificate to include this if the Society so desired.

Another alternative is to provide space for typing the physician's name, in addition to the space allowed for signature. His main reason for making these suggestions is to facilitate the work of the Department. By random sampling, it has been estimated that on about half of the certificates received, the physician's signature is illegible. thus requiring consultation and other directory service in order to clarify the situation.

Therefore it is the recommendation of the committee that both these suggestions be approved—the space for the physician's Illinois license number, and the space for his name to be typed in.

MOTION: (DuPuy-Goodyear) that the Council concur in the recommendation of the Committee. (Motion carried.)

Report of Editor

Dr. Van Dellen reported as editor. He stated that the March issue of the Journal was already some 213 pages in length—that it contained the minutes of the House for the December session, the annual reports for the May meetings of the House, and that portion of the scientific program available for publication. The specialty groups in Chicago might well be considered as a source of future scientific material for publication. This may necessitate stenographic coverage if and when something desirable becomes available for us.

Emeritus and Retired Members

MOTION: (Fullerton-Piszczek) that the Emeritus and Retired members be elected as listed. (Motion carried.)

EMERITUS

Abelio, George	Chicago	C.M.S.
Bondurant, Flint	Cairo	Alexander
Geiger, John W.	LaSalle	LaSalle
Hilkevitch, B. H.	Chicago	C.M.S.
Norris, Frank	Jacksonville	Morgan
Scatliff, H. Kenneth	Chicago	C.M.S.

RETIRED

Ball, Fred E.	Florida	C.M.S.
Beil, Harry H.	Florida	C.M.S.
Eiss, D. W.	Chicago	C.M.S.
Hunter, James F.	Cairo	Alexander
Oliver, H. E.	Chicago	C.M.S.
Rossman, Edward J.	Aurora	Kane
Steele, Pierre	Decatur	Macon
Wojniak, Frank	Florida	C.M.S.

Bills Approved

MOTION: (Piszczek-Fullerton) that the bills as audited by the finance committee be approved. (Motion carried.)

Dr. Lull reported that it was the recommendation of the Executive Committee that stenotype service be secured for the May meeting of the House of Delegates.

MOTION: (O'Neill-Piszczek) that the secretary inform the Sherman Hotel that the room assignment for the Council meeting was noisy and not satisfactory. (Motion carried.)

MOTION: (Piszczek-Fullerton) that the council go into executive session. (Motion carried.)

12:35 p.m.

Respectfully submitted,

GEORGE F. Lull, M.D., Secretary

THE P. R. PAGE

John A. Mirt

Unlabeled poison hazards cited

A new booklet entitled "Hidden Hazards — the Unlabeled Poison Problem" is being distributed by AMA's Committee on Toxicology.

"Hidden Hazards" presents the poison problem in the U.S. and tells what can be done to help solve it. The booklet states that "latest U.S. statistics show that as many as 1,422 persons died from accidental over-exposure to packaged chemicals in one year . . . . an impressive number for a cause of death that is largely preventable." Concerned by these figures, the AMA is urging passage of federal legislation requiring precautionary labeling of all hazardous substances used in home and industry which are not now required by law to carry warnings.

The AMA urges state and county medical societies to launch educational programs based on this booklet as well as to inform congressmen of their official support of the bill. A special program-planning section will aid medical societies in planning these campaigns. Address the Committee at 535 N. Dearborn St., Chicago, for copies of the booklet.

Opinion surveys are revealing

Local opinion surveys concerning physicians and the medical care they are providing are apt to reveal surprising information which can be useful in guiding PR programs. For example, take the results of a Connecticut county medical society's survey.

The study showed that 81 per cent reported no trouble in getting a physician when one was needed, and that 91 per cent considered the care given by the family physician was good or excellent.

In the matter of costs, 77 per cent said office charges were about right, and 70 per cent believed that rates for home calls were reasonable. However, only 46 per cent reported that surgical costs were proper; 16 per cent, mostly in the low income group, said they were too high.

Costs over which physicians have no control came in for most of the criticism. Prescription prices were approved by 39 per cent but regarded as too high by 43 per cent. There was an even split in opinions concerning hospital costs.

Disturbing was the news that only 40 per cent of those questioned have ever heard of the county medical society and that 83 per cent were not aware of the emergency medical service it had set up.

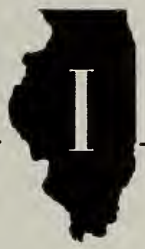
The answers disclosed where the PR program was weak, and where efforts should be concentrated. Other county medical societies could be guided by similar studies.

PR tip of the month

An Oregon county medical society has prepared an attractive poster-size first aid chart for athletic injuries, designed for display in school locker rooms.

The chart gives tips for initial handling of such common problems as dislocations, spike wounds, sprains, fractures, and sunstroke, but stresses in bold letters "Call physician immediately — Don't wait." Space is provided for listing the name, address, and telephone number of the team physician, a hospital, and ambulance service. The charts were distributed to all high schools in the county.

From the Secretary's Office



Casually speaking . . .

On April 3 a joint meeting of the Illinois Hospital Association and the Illinois State Medical Society was held at the Hotel Sherman. Over 250 hospital administrators, trustees and staff physicians from 85 hospitals attended. Dr. Maurice Hoeltgen appeared on a panel, and Dr. Joseph T. O'Neill was the luncheon speaker.

Many important items will come up in the House of Delegates meeting in May. Remember that you may attend the sessions and appear before reference committees in your capacity as a member of the Illinois State Medical Society.

The Chicago office is moving to 360 N. Michigan Avenue May 1. The Monmouth office will close after the annual meeting and be consolidated with the Chicago office at the new address.

Don't forget the big annual dinner on Wednesday, May 25. Get your tickets when you register so as to get choice location.

At the P.R. luncheon Tuesday, May 24, a federal judge will review six months' experience with Impartial Medical Testimony in the federal courts of Northern Illinois.

There have been four statewide and one downstate mailing from our Monmouth office so far this year. This is in addition to regular newsletters, membership cards, etc. Our postage meter there registers nearly $1,800.

At least two-thirds of all dues have been received in the state office. This amount plus that in the pipeline means we are in good shape financially.

Dr. Michael DeBakey of Houston, Texas, will deliver the first Harold M. Camp Memorial Lecture at the annual meeting at 10 a.m., May 25. His subject will be "Surgical Patterns of Atherosclerosis."

Very shortly a mailing will go out to all Illinois hospitals consisting of a letter to the administrator requesting him to give to chiefs of medicine and surgery certain enclosures relative to the annual meeting. There will also be material to use on the bulletin boards for the house staff.

For the first time, the Illinois State Medical Society will have closed circuit TV at the annual meeting. This will be at 9:00, Wednesday morning, and will show early care of the stroke patient. See your program for details.

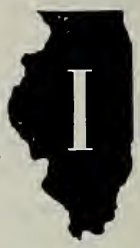
Fifty Year Club Luncheon

Dr. Andy Hall, chairman of the Fifty Year Club since its founding in 1937, will preside again this year at the annual complimentary luncheon honoring the members of the club, Tuesday, May 24, at 12 noon.

All physicians who have been in the practice of medicine for fifty years or more will be guests of the Illinois State Medical Society at one of the most popular social functions held during the annual meeting.

Tickets for the luncheon are complimentary, as always, and may be secured at the ticket desk during the morning, or from Dr. Hall.

AT THE EDITOR'S DESK



Carrots and Cholesterol

Don't look now but the vegetarians have just scored a victory. Trappist monks, who eat no meat, have less cholesterol in their blood than Benedictine monks, who do eat meat. It is a poorly controlled comparison because there are other factors. The Trappists are withdrawn from the world, devoted to contemplation, prayer, and physical labor. The Benedictines are teachers and preachers, involved with the world and its ways. They are not prohibited from drink nor smoke, whereas these are forbidden to the Trappists.

Swedes Drink Vaccine

Oral polio vaccine was given to 31,226 Minneapolis persons during March. This is Minnesota's first community-wide field trial of Lederle's single dose, cherry-flavored vaccine.

Anticarcinogenic Agents

A news release on Dr. Warren H. Cole's talk to the American Cancer Society included this interesting quote:

"We have treated 55 breast cancer patients by conventional methods—essentially the removal of the cancerous breast and tissues to which the cancer might have spread. We have treated 55 other women with conventional surgery plus the use of a drug, nitrogen mustard, at the time of operation and for a week or two following operation. Our purpose was to determine whether the drug would kill off stray cancer cells which we find in the bloodstream of 50 per cent of the patients even before surgery and the cancer cells which might have broken loose with removal of the tumor. Now—from two to three years following surgery—11 of the 55 women given only conventional surgery have died, while only two of the 55 given surgery plus nitrogen mustard have died. There have been 16 recurrences among those given only surgery and only 12 among those given drugs as well."

Pharmaceuticals

Samples of Syndecon are in your office now. Bristol Laboratories matched this with a news release for lay consumption. Syndecon was reported to be "the first combined medication to contain the new synthetic penicillin . . . . for use in combatting upper respiratory infections accompanying colds and influenza." It is combined with APAP, a pain reliever, and Naldecon, a decongestant.

The release is well timed and well worded. Penicillin for colds and influenza—tisk! tisk!

Roerig also has an synthetic oval penicillin (Maxipen). The advantages, according to their PR department, are a higher blood-serum level, rapid absorption from the gastrointestinal tract, and that it can be administered without regard to meals. What we want to know: Is it cheaper than other oral penicillin products?

Anthropan was reported recently as a new drug for arthritis that brings relief without the dangers of steriods. No mention was made of the fact that the drug is a substitute for aspirin. The only reference was that anthropan was absorbed five times as fast as aspirin and induces less gastric distress. The March 18 issue of the Medical Letter on Drugs and Therapeutics admits that it might be absorbed faster, but at 10 times the cost of equivalent dosage of aspirin. Medical Letter corrects the misconception "The implication in Orthropan literature that it takes

nearly two hours to get effective blood levels with aspirin is not supported by clinical studies. In two studies effective blood levels were reached in less than 60 minutes with aspirin."

Elipten is Ciba's new anticonvulsant drug. It is related to Doriden but does not put patients to sleep. Elipten has been tested clinically for more than three years in over 5,000 patients, and according to Ciba, it controls almost every type of epilepsy with a minimum of side effects.

Time will tell whether these claims can be substantiated. One of the investigators, Sheehan, reported his findings in the Irish Journal of Medical Science. He must have a huge following of epileptics because his study involved 1,000 epileptic patients and "Preliminary observations have shown it (Elipten) to be helpful in a small group of patients in whom no other combination of treatment had up to then been effective."

Naqua is Shering's new oral diuretic. The competition in this field is getting keener.

ZeaSorb Foot Powder is a new foot powder that absorbs many times its own weight of moisture without caking. According to a report by Cleveland J. White M.D., the powder base "has marked therapeutic efficiency in inflammatory or hyperhidrotie states to reduce the growth of bacteria and fungi by the absorption of excessive moisture." He used the powder in 2,079 cases, and its bacteriostatic properties are such that the number of bacteria have been reduced over 90 per cent in 36 hours, fungi over 87 per cent in 48 hours. It was used successfully in 548 cases of severe hyperhidrosis of the eccrine type and in 1,172 cases of superficial fungous infections where excessive hyperhidrosos existed with widespread inflammatory involvement. It is to be released March 15 in certain key-test areas by the Stiefel Laboratories of Oak Hill, N. Y.

Who vs Anopheles

Malaria has been eradicated from areas inhabited by some 46 million persons during the past 20 years. The disease continues to be a threat to 83 million persons, but their countries and territories have organized programs in varying stages of development. The World Health Organization has set complete eradication as the goal. It means a continued search for new insecticides and more active drugs, along with research on insect resistance. Never before in history has man placed so much talent at the service of a noble cause. Dedicated workers have been likened to an army of peace on the march.

Transplanted Teeth

The first tooth bank was started by an Arizona dentist, Dr. E. M. Pafford, Jr. He has collected more than 600 transplantable teeth in the past seven years and has performed more than 200 replacement operations. Eighty per cent have been successful.

Average Salaries

According to HEW, average salaries for full-time faculty members in four-year colleges rose from an average of $6,160 to $6,810 during the past two years. The average for public institutions is $7,040 and for private, $6,510.

Our pet peeve for the month

The physican who recommends hospitalization to the patient for a diagnostic workup and is told "Blue Cross will pay the bill." The patient blames — not the physician — but the hospital and the insurance carrier saying, "I've been paying premiums for years and look what happens the first time I go to the hospital." Physicians should remember that hospital insurance was created to counteract socialized medicine. It must be successful or . . . . .

Leap Year

The cover on the February 16, 1960 *Hospitals* has this caption "Nurses' residence designed with the residents in mind." We wonder if they have the Ob-Gyne resident in mind or just any resident so long as he is male, young, and single.

Thoughts

Nature and education are somewhat similar. The latter transforms man, and in so doing creates a second nature.—Democritus

It is chiefly upon the lay citizen, informed about science but not its practitioner, that the country must depend in determining the use to which science is put, in resolving the many public policy questions that scientific discoveries constantly force upon us.

—David E. Lilienthal

ANNOUNCEMENTS



Illinois Obstetrical and Gynecological Society Annual Meeting

The annual meeting of this society will be held in the Jade Room of the Sherman Hotel, Chicago, on Monday, May 23. Following the business meeting at 9 a.m., the following program will be presented:

10:00 "Presentation Summaries of the First Five Year Program of Blood Loss and Allied Factors," by members of the Committee and Williard Scrivner, M.D., Chairman.

10:45 "Management of the Sensitization Problem," Thomas Wilson, M.D. and Warren Greenwold, M.D.

11:15 "Uncommon Lesions of the Cervix," Charles Galloway, M.D.

11:45 "Maternal Mortality—1959." Drs. Alan and Jack Sampson.

12:30 Luncheon—Room No. 107 (Make reservation with Secretary)

2:00 "Clinical Aspects of Ovarian Tumors," William Mengert, M.D.

2:45 "Parasitic Infection during Pregnancy," Carol Birch, M.D.

On Sunday, May 22, 6 p.m., the officers and councillors will meet for the annual executive committee meeting in the Holiday Room.

NU alumni luncheon

On June 14 during the AMA convention in Miami Beach, alumni of Northwestern University Medical School will hold their annual luncheon in the Imperial Room of the Roney-Plaza Hotel at 12:30 p.m. Chairman of arrangements is Dr. Herbert W. Virgin, Jr. (Med. '32) of Miami. Speaker will be Dean Richard H. Young.

Tickets at $3.50 each are available from the University Medical Alumni Office, 303 East Chicago Ave., Chicago 11, or may be purchased at the registration area of the convention.

Illinois Medical Alumni Seminar

The Medical Alumni Association of the University of Illinois has scheduled its annual medical seminar for Monday, May 23.

The annual banquet will be held at the Illini Union, 715 S. Wood St., following the day's program of seminars, lectures and clinics in Room 106 of the College. Officers for 1960-61 will be elected following the banquet. Guest speaker will be Mr. Sydney J. Harris, Chicago Daily News columnist. Classes celebrating reunions at the seminar are 1905, '10, '15, '19, '20, '25, '30, '35, '40, '45, '50, and '55. Each class will have a reserved table.

Program for the day:

9:00 a.m.	Registration: Lobby, 1853 W. Polk St.
9:30	"Fluid Balance in Infants and Children," Heyworth N. Sanford, M.D., head, Department of Pediatrics
10:15	"Induction of Labor," William F. Mengert, M.D., head, Department of Obstetrics and Gynecology, and James H. McClure, M.D., assistant professor of obstetrics and gynecology
11:00	Intermission
11:15	"Intestinal Obstruction," Warren H. Cole, M.D., head, Department of Surgery
12:00	"Glomerulonephritis, Nephrosis, and the Nephrotic Syndrome," Robert M. Kark, M.D., professor of medicine
1:00 p.m.	Luncheon
2:30	"Modern Concepts in Differential Diagnosis and Treatment of Jaundice," Edmund F. Foley, M.D., professor of medicine, William J. Grove, M.D., associate professor of surgery.

3:45	"Sarcoidosis," Adolph Rostenberg, M.D., head, Department of Dermatology
4:15	Intermission
4:30	"Carcinoid Tumors," Ruth Wong, M.D., assistant professor of pathology; Harry A. Bliss, M.D., associate professor of medicine.
5:30	Social Hour
6:30	Alumni Banquet

Alumni and their guests are invited. For further information write Dr. Louis R. Limarzi, associate professor of medicine, Room 216, University of Illinois Research and Educational Hospitals, 840 S. Wood St., Chicago 12.

June clinics for crippled children

Twenty-one clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. Fifteen general clinics will provide diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing service. There will be two special clinics, respectively, for children with cardiac conditions, with cerebral palsy, and with rheumatic fever. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 1	Carmi, Carmi Township Hospital
June 1	Hinsdale, Hinsdale Sanitarium
June 2	Effingham, St. Anthony Hospital
June 3	Chicago Heights (Cardiac), St. James Hospital
June 8	Alton (Rheumatic Fever), Alton Memorial Hospital
June 8	Champaign-Urbana, McKinley Hospital
June 9	Springfield, St. John's Hospital
June 10	Evanston, St. Francis Hospital
June 14	East St. Louis, St. Mary's Hospital
June 14	Peoria, Children's Hospital
June 15	Chicago Heights, St. James Hospital
June 16	Elmhurst (Cardiac), Memorial Hospital of DuPage County
June 16	Rockford, St. Anthony's Hospital
June 21	Belleville, St. Elizabeth's Hospital
June 22	Elgin, Sherman Hospital
June 22	Springfield, p.m. (Cerebral Palsy), Memorial Hospital
June 23	Bloomington, a.m. (General), St. Joseph's Hospital, p.m. (Cerebral Palsy)
June 28	Effingham (Rheumatic Fever), St. Anthony Hospital
June 28	Peoria, Children's Hospital
June 29	Centralia, St. Mary's Hospital

Postgraduate seminar in arthritis

This seminar will be held June 11 and 12 at the Diplomat Hotel, Hollywood-By-the-Sea, Fla., immediately preceding the meeting of the American Medical Association. Speakers will include Leon Sokoloff, Gene H. Stollerman, Alexander B. Gutman, Edward F. Rosenberg, Charles Ragan, Theodore B. Bayles, Joseph L. Hollander, Philip S. Hench, Lawrence E. Shulman, Morris Ziff, and Edward W. Lowman. The program includes a panel discussion on the treatment of rheumatoid arthritis. This course is acceptable for 8 hours Category 1 credit. The registration fee is $15. For further information address the Seminar Committee, Florida Chapter, American Rheumatism Foundation, 1206 Huntington Medical Building, Miami 32.

Grant to aid rehabilitation treatment

A gift of $100,000 from an anonymous doner to the new trust fund in Chicago to aid in treating the physically handicapped has been announced by the Rehabilitation Institute of Chicago.

Many disabled individuals who could be helped back to a more self-sufficient and productive life cannot always pay the full cost of treatment. Gifts to the endowment fund make it possible to extend services of the Institute to a greater number of people.

Board examinations

American Board of Obstetrics and Gynecology announces that applications for certification in the American Board of Obstetrics and Gynecology, new and reopened, Part I, and requests for reexamination in Part II are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline

for receipt of applications is August 1, 1960. No applications can be accepted after that date. As announced in the current Bulletin, "after July 1, 1962, this Board will require a minimum of three (3) years of approved progressive residency training to fulfill the requirements for admission to examination. After the above date, training by preceptorship will no longer be acceptable. Therefore the initiation of preceptorships will not be approved after July 1, 1960." Application fee ($35.00), photographs, and lists of hospital admissions must accompany all applications. Address Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6.

Annual Oregon Cancer Conference

The Second Annual Oregon Cancer Conference is being held July 7 and 8 in Portland under the joint sponsorship of the Oregon State Medical Society, the Oregon Division of the American Cancer Society, and the University of Oregon Medical School.

All sessions will be held in the new Sheraton Hotel. The entire expense of the conference is being underwritten by the Oregon Division of the American Cancer Society. There will be a charge for the luncheons and banquet.

Guest lecturers include the following physicians: Oscar Creech, Jr., of New Orleans, J. Hartwell Harrison of Boston, Henry Jaffe of Los Angeles, I. S. Ravdin of Philadelphia, and R. Wayne Rundles of Durham, N.C.

A copy of the complete program and hotel reservation forms may be obtained by writing to Roscoe K. Miller, Executive Secretary, Oregon State Medical Society, 2164 SW Park Place, Portland 5.

Rocky Mountain Cancer Conference

This annual cancer conference will be held in the new Denver Hilton Hotel in Denver July 20-21. Nearly 900 physicians from all over the nation are expected to attend.

The regional conference, worth 10 AAGP Category 1 credits, is jointly sponsored by the Colorado State Medical Society and the state division of the American Cancer Society.

Tentative program plans call for symposia at the morning sessions on "Skin Cancer" and on "Thyroid Lumps." Afternoon sessions will be devoted to papers on cancer detection and treatment. Physician participants include E. Vincent Askey, Los Angeles; R. Lee Clark, Jr., of Houston; Warren H. Cole, Chicago; A. James French, Ann Arbor, Mich.; Roy L. Kile, Cincinnati; Wendell G. Scott, St. Louis; H. W. Schmidt, Rochester, Minn.; and Willard P. Vanderlaan, La Jolla, Calif.

For further information address the Conference, 835 Republic Building, Denver 2.

NU shortens medical training

Northwestern University has revised its curriculum to help eliminate the present sharp division between premedical and medical education and to reduce the time required for completing the course from the traditional seven or eight years to six years.

In 1960 the medical school will accept 25 talented students directly from high school. Courses studied the first and second years will be about one-third in the physical and biological sciences, one-third in behavorial sciences, and one-third in humanities.

A rearranged program, to affect all medical students, will coordinate the teaching of basic sciences with laboratory aspects to be presented in a combined laboratory; normal and abnormal aspects of anatomy and pathology will be studied together.

Clinics will be reorganized to stress the concept of comprehensive medicine, and students will follow patients or families for several years to learn how social, economic, and psychological factors influence the course of illness.

Advantages of the new program include beginning it at an advanced level, eliminating undesirable repetition, and permitting more rigorous and thorough development of the subject matter in a shorter period of time. It is hoped the new program will attract scientifically-orientated students now discouraged by long years of training in medicine and stimulate interest in a combined program for the Ph.D. and M.D. degrees that may provide persons badly needed in academic medicine.

Administrators believe the program will eliminate the sense of competition characteristic of premedical students anxious to keep a high academic average necessary for admission to medical school. Eventually students taking premedical training elsewhere will be able to take advantage of the shortened program.

Changes related to Medicare

The Blue Shield Plan of Illinois Medical Service, fiscal agent of the ISMS for the Medicare program, has announced the following changes in medicare permits and conditions under which dependents may receive benefits.

DD Form *1173* Identification Card. This has been established as the primary means of identifying patients as dependents eligible to receive care authorized under the Medicare program. However, DD Form 1173 is valid *only from date of issue and through the expiration date shown thereon.*

Cards bearing an expired date, no date, or an "indefinite" date are not acceptable. When such cards are presented to the physician, the case should be treated as though the card were not available and should be documented as follows:

In Emergeny Cases the claim form must be accompanied by a statement from the attending physician certifying the reason such a form was not available and stating that the case was an emergency along with one of the following types of collateral identification supporting the fact that the patient was eligible for civilian Medicare benefits during the period of service:

1. Statement by local commander that patient was eligible.
2. Other official uniformed services document signed by an official and reflecting that patient was eligible.
3. Statement of physician, hospital authority, or other source of care that he has personal knowledge that the patient was eligible.
4. An entry in the space on Claim Form DA Form 1863, describing civilian type identification belonging to the party (dependent, parent, sponsor, legal or acting guardian) certifying to the patient's eligibility on the claim form, such as social security card, number and state of driver's license.

In Non-Emergency Cases where the DD Form 1173 is not available at time care is commenced, an eligible dependent may begin to receive authorized care from a civilian source as a potential beneficiary of the program, but payment is contingent upon the claim being documented either by

1. A statement from an official authorized to issue DD Forms 1173 indicating that patient is an eligible dependent, and including the name, rank, or grade and position of the issuing official and stating that he is authorized to issue the DD Forms 1173.
2. Information from a DD Form 1173 with a date of issue later than the "from" date set forth, provided there is attached to the claim a letter from the official issuing the DD Form 1173 indicating that the patient was an eligible dependent during the period covered by the claim.

DD Form *1251*—Medicare Permit. The designation of DD Form 1251 has been changed from "Medicare Permit" to "NonAvailability Statement Dependents' Medical Care program." DD Forms 1251 bearing either of these titles will be equally valid and acceptable.

Procurement Of Blood Under Medicare Program. The Office for Dependents' Medical Care recommends that physicians providing care under the Medicare program should urge relatives of the patient to donate blood as required. In those instances where blood must be purchased, the government cannot pay more than $50 for each withdrawal; and the purchases must be made by a hospital and included on its claim submitted under the program.

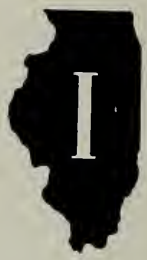
Dr. Casberg to India

Dr. Melvin Casberg, son of missionary parents in India, became director of the Christian Medical College at Ludhiana, Northern India, in March, succeeding Dr. Eileen R. B. Snow, retired.

Dr. Casberg was formerly dean of St. Louis University School of Medicine and vice president of medical affairs, University of Texas.

Ludhiana is one of only two top-standard coeducational Christian medical colleges serving Southern Asia. The medical college and 350-bed hospital has a teaching staff of 74 men and women and ministers to some 60,000 patients yearly.

NEWS of the STATE



COUNTY

Adams

Dr. Gene Klingberg, assistant professor of pediatrics at Washington University, St. Louis, spoke on "Jaundice in Infancy and Childhood" at the April meeting of the Adams County Medical Society.

Champaign

Dr. Percival Hopkins, a trustee of the American Medical Association and past president (1948-49) of the Illinois Medical Society, spoke on "Recent Medical Legislation" at the April meeting of the Champaign County Medical Society.

Cook

Appointments. Dr. Lowell T. Coggeshall has been appointed a vice-president of the University of Chicago, where he has been dean of the division of biological sciences since 1947. Dr. Coggeshall primarily will be responsible for the development of medical research programs and facilities. In addition, he will seek to build up resources for the general activities of the biological sciences division.

Dr. Samuel Andelman, associated with the Chicago health department since 1956, has been named Chicago commissioner of health to serve with Dr. Herman N. Bundesen, president of the Board of Health. Dr. Andelman graduated from the University of Illinois School of Medicine and has a degree in public health from the University of Michigan.

Appointments. Dr. Hilger P. Jenkins, clinical professor of surgery at the University of Illinois, has been appointed professor of surgery at the University of Chicago.

Dr. Newton C. Mead, assistant professor of orthopedic surgery at Northwestern University Medical School, has been appointed head of orthopedic surgery at Evanston Hospital.

Dr. Robert D. Moore, presently associate professor of surgery at the University of Chicago College of Medicine, on July 1 will become professor of surgery and chief of the orthopedic section of the department of surgery.

Officers Elected. The Chicago Diabetes Association has selected the following physicians as officers: James B. Hurd, Wilmette, president; M. David Allweiss, Wilmette, reelected first vice president; Ralph E. Dolkart, Chicago, secretary.

Branch Society Directory. The Jackson Park Branch of the Chicago Medical Society has published its first directory of members for 1959-60. Per se, this is admirable; it has even gone further by publishing as a section a classified roster in a manner to rival the "yellow pages."

Dr. Eugene F. Lutterbeck, secretary, sent the membership a form to assure correct and up-to-date information. Tabulation revealed information not known to the society. Among 455 members, 35 different fields of practice were represented. (Each physician was asked to name not more than two fields.) The two largest specialties are general practice and internal medicine, with obstetrics and gynecology a runner-up; 58 members are women physicians. Congratulations are due the group for assembling detailed information.

Society Meetings. At the April meeting of the Society of Medical History of Chicago, Dr. Joseph P. Evans, professor of neurological surgery at the University of Chicago, spoke on "Harvey Cushing—Surgeon and Teacher," and Dr. E. Alan Richardson, a research fellow at the university, on "Oscar Pfister: A Study in Psychoanalysis and Religion."

Harold H. Nelson, clinical associate in the department of neurology and psychiatry, Stritch School of Medicine of Loyola University, addressed the LaSalle County Medical Society at the Prairie Lake Gun Club near Marseilles, April 14, on "Geriatric Psychiatry."

Donald L. Unger, clinical assistant in medicine, Stritch School of Medicine of Loyola University, addressed a joint meeting of the Whiteside and Lee County Medicial societies in Sterling, April 21, on "Recent Advances in Allergy."

Sydney Kofman, clinical instructor in medicine, University of Illinois College of Medicine, addressed the Licensed Practical Nurse Association, Division One, April 27, on "Cancer, a Geriatric Problem?"

The Seventh Richard H. Jaffe Memorial Lecture of the Institute of Medicine of Chicago was delivered by Dr. Edith Potter, professor of pathology at the University of Chicago, on "Disease of the Liver in the Fetus and Young Infant."

Dr. S. Leon Israel, professor of obstetrics and gynecology at the Graduate School of Medicine, University of Pennsylvania, addressed the Chicago Gynecological Society by invitation in April on "The Hypothalamus and Us."

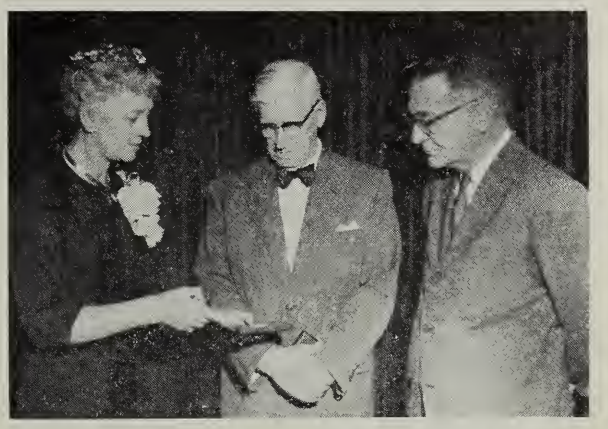
At the meeting of the Chicago Urological Society in April, Dr. John B. Graham spoke on "Epididymitis Following Unilaterial Vasectomy and Prostatic Surgery," and Dr. Austin B. Zeitlin, on "Bilaterial Torsion of the Hydatid Testis." The Presidential Address was delivered by Dr. Cornelius W. Vermeulen on "An Attempt to Delineate the Process of Stone Formation."

The Chicago Surgical Society's Annual Spring Lectureship was delivered by Dr. J. Englebert Dunphy, professor and head of the department of surgery at the University of Oregon Medical School, on "Wound Healing, New Concepts and Old Principles."

Fifty Years of Practice. Dr. Charles Salmon, who has practiced over half a century in Englewood, was recently honored at a retirement testimonial dinner given by fellow surgeons and physicians. Dr. Salmon has been on the Englewood Hospital staff since his internship there in 1908.

Stress Studies Grant. The Chicago Medical School has been granted about $100,000 by the U. S. Air Force for studies on the effect of stress in space on metabolism, endocrine glands, nervous system, and internal structures of the body.

Medals Awarded for TB Control. The Tuberculosis Institute of Chicago and Cook County has cited Drs. James H. Hutton and Jerome R. Head for distinguished service in the field of tuberculosis control. Both have received medals. Criteria for the recognition include administration, research, and leadership.



At award ceremony Drs. James H. Hutton (center) and Jerome R. Head (right) received medals from Mrs. Proehl H. Jaklon, chairman of awards committee and secretary of the Institute, for their distinguished service in tuberculosis control in Chicago and Cook County.

Dr. Hutton was cited as the "standard bearer" in the fight waged against TB in the state since World War II. As chairman of the tuberculosis control committee of the Chicago Medical Society in 1946, he saw that an all-out drive was urgent. In that period 2,000 persons died of TB in Chicago each year, and 500 to 600 with active cases awaited their turn to get into the Municipal Tuberculosis Sanitarium. He led in organization of the Statewide Committee for Eradication of Tuberculosis and, as spokesman for the 75 groups in its membership, went to Springfield with a program. As a result, the legislature established state TB hospitals in Chicago and Mt. Vernon and appropriated funds to permit the MTS and downstate sanitariums to make use of the new beds. As a measure of the gains against TB during the period of his leadership, Chicago had 476 TB deaths in 1958. No longer is there a waiting list at the hospital.

Among Dr. Head's contributions was his activity in promoting the Suburban Cook County Tuberculosis Sanitarium District and his service as its first president. As chairman of a subcommittee of the Chicago Medical Society's tuberculosis control committee in 1946, he surveyed the TB facilities in the county outside Chicago and

found them "very inadequate." He reported that in one year 167 persons, unable to get hospital care, died of the disease. The district was approved by the voters in 1947, and Dr. Head was chosen president of the first board of trustees. He has also served as a professor of surgery at Northwestern University Medical School and in that post has contributed much to the modern techniques of chest surgery.

Hancock

Safety Award. Memorial Hospital in Carthage has won a first place plaque in the 1959 Hospital Safety Contest sponsored by the American Hospital Association and the National Safety Council.

The 299 hospitals taking part in the competition were divided into eight groups according to number of employees. Memorial placed first in the group with less than 100. The contest was judged on the basis of the lowest number of injuries among hospital personnel in relation to number of man-hours worked during the year.

Lake

Two papers were presented at the April meeting of the Lake County Medical Society. Dr. Alexander E. Harvey, director of professional services at the VA Hospital in Downey, spoke on "Doctor-Patient Relationship in General Practice," and Dr. Thomas Worobec, chief of on NP-TB service of the hospital, on "Diagnosis, Prognosis and Treatment of So-Called 'Open-Negative' Tuberculous Cavities."

Madison

At the April meeting of the Madison County Medical Society, the Forand Bill was discussed and instructions given to the delegates who are representing the society at the Illinois State Medical Society meeting in May.

Peoria

First Executive Secretary. The Peoria Medical Society has announced the appointment of David W. Meister as its first executive secretary. The new office in the National Bank Building will be a clearing house for all activities of the society. Mr. Meister's duties will include coordination of society activities and expansion of its public relations program. He has been director of public relations for Bradley University.

Polio Program. The county medical society has approved the P.T.A. program for mass polio immunizations.

Rock Island

Dr. Anthony J. Pisciotta of Marquette University, Milwaukee, spoke at the April meeting of the Rock Island County Medical Society on "Coagulation and Hemorrhagic Disorders."

Sangamon

"Pediatric Surgery of the Newborn" was the subject of the April meeting of the Sangamon Medical Society. It was presented by two physicians from St. Louis University, Drs. Armand E. Broderer and J. Eugene Lewis, Jr.

Vermilion

Fifty Year Club. Five physicians for the county became eligible this year for their 50-year pins and certificates, which were presented at the March meeting of the Vermilion County Medical Society. Physicians honored were Drs. W. T. Dawson, C. L. Bennett, Carl S. Williamson, W. T. Snider, and E. G. C. Williams. Dr. Williams, who is retired and living in Fort Myers, Fla., received his certificate and pin by mail.

Will-Grundy

At the March meeting of the Will-Grundy Medical Society, Dr. Perry G. Pratt, Joliet, reported on Legislative Conference Forand Bill, and Dr. B. Klein, also of Joliet, discussed the Blue Shield Insurance Plan for the aged.

GENERAL

Research in Sudden Deafness. Northwestern University is seeking 50 persons who have become deaf over night or in a comparatively short time to participate in a series of tests and examinations lasting about six hours. Volunteers must be less than 60 years old and have hearing loss in only one ear. The project is under the joint direction of Prof. James Jerger, associate professor of audiology in the school of speech, and Dr. George W. Allen, director of teaching and research in the department of otolaryngology of the medical school. Persons interested in aiding in the project may address letters to the Speech Annex Building, Northwestern University, Evanston, Ill. All testing will be done at the medical school, 303 E. Chicago Ave., Chicago.

Appointments. Dr. Harry Wright, medical director of Quadri-County health department, Metropolis, has been appointed by Governor Stratton to serve as representative of Southern Illinois on the Citizens' Advisory Committee on Community Mental Health Grants. Physicians reappointed to the committee include Dr. F. Garm Norbury, Jacksonville; Dr. Donaldson F. Rawlings, Springfield; and Dr. Groves B. Smith, Godfrey.

Lectures Arranged through the Illinois State Medical Society

Joseph Ceithaml, Ph.D., dean of medical students at the University of Chicago, took part in the Second Annual Career Conference sponsored by the Back of the Yards Council, March 26, at St. John the Baptist School, speaking on "Medical Careers."

DEATHS

John H. Alderson*, Pana, who graduated at Loyola University School of Medicine, Chicago, in 1923, died March 10, aged 68. He was formerly the mayor of Pana.

Manuel Alvarez*, Bluffs, who graduated at Dearborn Medical College, Chicago, in 1904, died December 21, aged 86.

Arrie Bamberger*, Chicago, a graduate of Rush Medical College in 1906, died March 13, aged 72. He was an emeritus professor at the University of Illinois, attending clinical surgeon at Cook County Hospital, and a founding member of the American Board of Surgery. He was also chairman of the board of Jackson Park Hospital, which he owned until last year.

Albert C. Baxter*, Springfield, who graduated from the University of Michigan Medical School, Ann Arbor, in 1907, died March 17, aged 79. He was formerly State Health Department director.

James Valentine Beynon*, Rockford, who graduated at Chicago College of Medicine and Surgery in 1913, died January 1, aged 75.

John J. Cronin, Chicago, who graduated at the University of Illinois Medical School in 1906, died March 30, aged 80.

Harry Glenn Ebersole*, Monmouth, who graduated at Northwestern University Medical School in 1917, died in March, aged 69.

Michael H. Ebert*, retired, Cleveland Heights Ohio, formerly of Chicago, who graduated at Rush Medical College in 1917, died March 12, aged 74. He was author of several dermatological research papers and was past-president of the Chicago Dermatological Society and also of the American Academy of Dermatology and Syphilology. He was a former head of the department of dermatology at the University of Illinois School of Medicine in Chicago and also held the same title at the Presbyterian Hospital. He was a former director of the American Dermatology Association.

Clarence George Fischer*, Peoria, who graduated at Rush Medical College in 1920, died January 18, aged 67. He was member and past-president of the staff of St. Francis Hospital.

Emil H. Grubbe*, retired, Chicago, who graduated at Hahnemann Medical College, Chicago, in 1898, died March 26, aged 85. He was credited with being the first man to use x-rays as healing agents when, on January 29, 1896, he began treating a woman cancer patient. Dr. Grubbe later became the world's first professor of roentgenology and head of the radiology department at Hahnemann, where he taught more than 7,000 doctors how to use radiation as a medical treatment. He also established the first hospital x-ray department. He began his experiments in creating x-rays by putting an electrical charge through a vacuum tube composed of platinum in late 1895, about the same time Wilhelm K. Roentgen, the famed German physicist discovered x-rays. Six months after his experiments Dr. Grubbe underwent the first of 93 operations for irritations from radiation burns that ultimately developed into cancer. After undergoing the last of his operations, he bequeathed his estate of $158,000 to the University of Chicago for the establisment of a radiation therapy foundation. A month before his death the American Cancer Society awarded him a citation for his "genius and sacrifices as a pioneer, teacher, writer and researcher in the science of radiology."

Ira Karr Humphrey*, Cordova, who graduated at Rush Medical College in 1906, died January 14, aged 77.

Lester T. Johnson*, Chicago, who graduated at Loyola University School of Medicine, Chicago, in 1921, died April 4, aged 68.

J. Edward Kelley*, Chicago, who graduated at Northwestern University Medical School in 1905, died March 19, aged 78. He had been a staff surgeon of Mercy Hospital since 1905.

Alfred Walter Kneucker*, Chicago, who graduated at Medizinisch Fakultät der Universität, Vienna, in 1929, died January 12, aged 55, in Vienna while he was lecturing in Europe on his research on the problem of human deaths. Author of two books and many papers, Doctor Kneucker also discovered that the kidney gives an electrical potential. Formerly assistant professor of surgery at Chicago Medical School, visiting professor of the University of California (Santa Barbara), and head of the department of physiology, Riverside (California) College, he has also served on the staffs of the American, Northwest, and Mount Sinai Hospitals. At various times he has been chief of the department of urology, General Hospital of Shanghai, China.

Jacob A. Kohn*, Camarillo, Calif., formerly of Chicago on the staff of Grant Hospital, and a graduate at Chicago College of Medicine and Surgery in 1915, died March 30, aged 68.

George Moe*, Berkeley, who graduated at Chicago Homeopathic Medical College in 1893, died October 29, aged 97.

Carl T. Olson*, retired, St. Petersburg, Florida, formerly of Chicago, who graduated at Rush Medical College in 1919, died April 1, aged 67. He was medical director for the midwest division of Liberty Mutual Insurance company for 11 years. Previous to that appointment, he served as medical director for Fanstell Metallurgical Corporation, North Chicago.

Rollo K. Packard*, retired, Los Angeles, Calif., formerly of Chicago, who graduated at Chicago College of Medicine and Surgery in 1911, died March 28, aged 74. He was a past president of the Illinois State Medical Society, and was president emeritus of Chicago Blue Shield and one of the founders and a former vice president of the Chicago Blue Cross. He formerly served as chief of staff and president, and board chairman of Woodlawn Hospital. He was a fellow of the International College of Surgeons and the American College of Surgeons.

Francis Joseph Pelant*, Newton, who graduated from the Chicago College of Medicine and Surgery in 1914, died December 5, aged 73.

Arthur M. Purves*, retired, Chicago, who graduated from Bennett Medical College, Chicago, in 1901, died April 2, aged 83.

Samuel D. Rosenthal*, Chicago, who graduated from the Chicago College of Medicine and Surgery in 1913, died March 16, aged 69. Dr. Rosenthal had practiced medicine in Chicago for almost half a century. He was a member of the staff of Franklin Boulevard Community Hospital and served as medical director for Goldblatt's for 30 years.

Roscoe E. Sutton*, Scales Mound, who graduated at the National University of Arts and Sciences, Medical Department, St. Louis, in 1912, died February 4, aged 74.

Stanley E. Telser*, Chicago, a graduate of the University of Illinois College of Medicine in 1937, died March 17, aged 48. He, his wife, and 14 year old son were among the victims killed in the crash of a Northwest-Orient airliner near Tell City, Ind. Dr. Telser was the medical director of the Chicago Health Center of the International Ladies Garment Workers Union.

Paul W. Tranter*, Chicago, who graduated from the University of Illinois College of Medicine in 1911, died March 26, aged 70.

James M. Young*, Orion, who graduated at the Chicago Medical School in 1933, died January 24, aged 59.

* Indicates member of the Illinois Medical Society.

Genetics and lung cancer

Herdan in a study on "The increase in the mortality due to cancer of the lung in the light of the distribution of the disease among the different social classes and occupations" shows that there is a pronounced negative correlation between the mortality due to inflammatory and infectious diseases and excess male mortality ratio due to lung cancer. He attributes this to the genetic makeup of a susceptible group whose inherent predisposition to lung cancer becomes more evident as tuberculosis, pneumonia, etc., give way to successful treatment. This would also become more evident with improved methods of diagnosis as has been previously mentioned. *James E. Russell. An Evaluation of the Literature Between Smoking and Lung Cancer. New Physician. March*, 1960.

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Thiamine HCl (B_1)	10 mg.
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Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
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BOOK REVIEWS



HANDBOOK OF CIRCULATION. Prepared under the direction of the Committee on the Handbook of Biological Data, Division of Biology and Agriculture, the National Academy of Sciences and the National Research Council. Analysis and compilation by Philip L. Altman. $7.50. Pp. 393. Philadelphia, W. B. Saunders, 1959.

When I first leafed through this volume and saw the numerous and extensive tables of data, I wondered if a review for the practicing physician would serve any useful purpose. This compilation of data does have an obvious place in the cardiovascular and pulmonary laboratory. And it is ready source of information exotic to medicine. Would you like, for instance, to impress your colleagues by knowing the blood volume of the American cockroach (either nymph or adult), of the red-throated loon, or perhaps of the codfish?

In a more serious vein, many of the tables should be of considerable value to the physician dealing with cardiopulmonary diseases. They represent a most convenient source of information on many functions whose quantitative measurements are becoming more and more important to clinical cardiology. The following list of tables, each one containing data on many parameters, is presented to illustrate some (by no means all!) of the clinically useful information available in this volume. The reviewer's comments are in parentheses:

Duration of electrocardiographic waves and intervals at different ages.

Physiologic heart sounds and murmurs. (*A valuable review of current concepts.*)

Drugs with cardiovascular effects: Sites of action. (*A broad summary with ready references to the next table which gives more specific details.*)

Drugs primarily used for disorders of the circulatory system. (*The table contains indications, doses, desirable and undesirable effects, and hemodynamic effects.*)

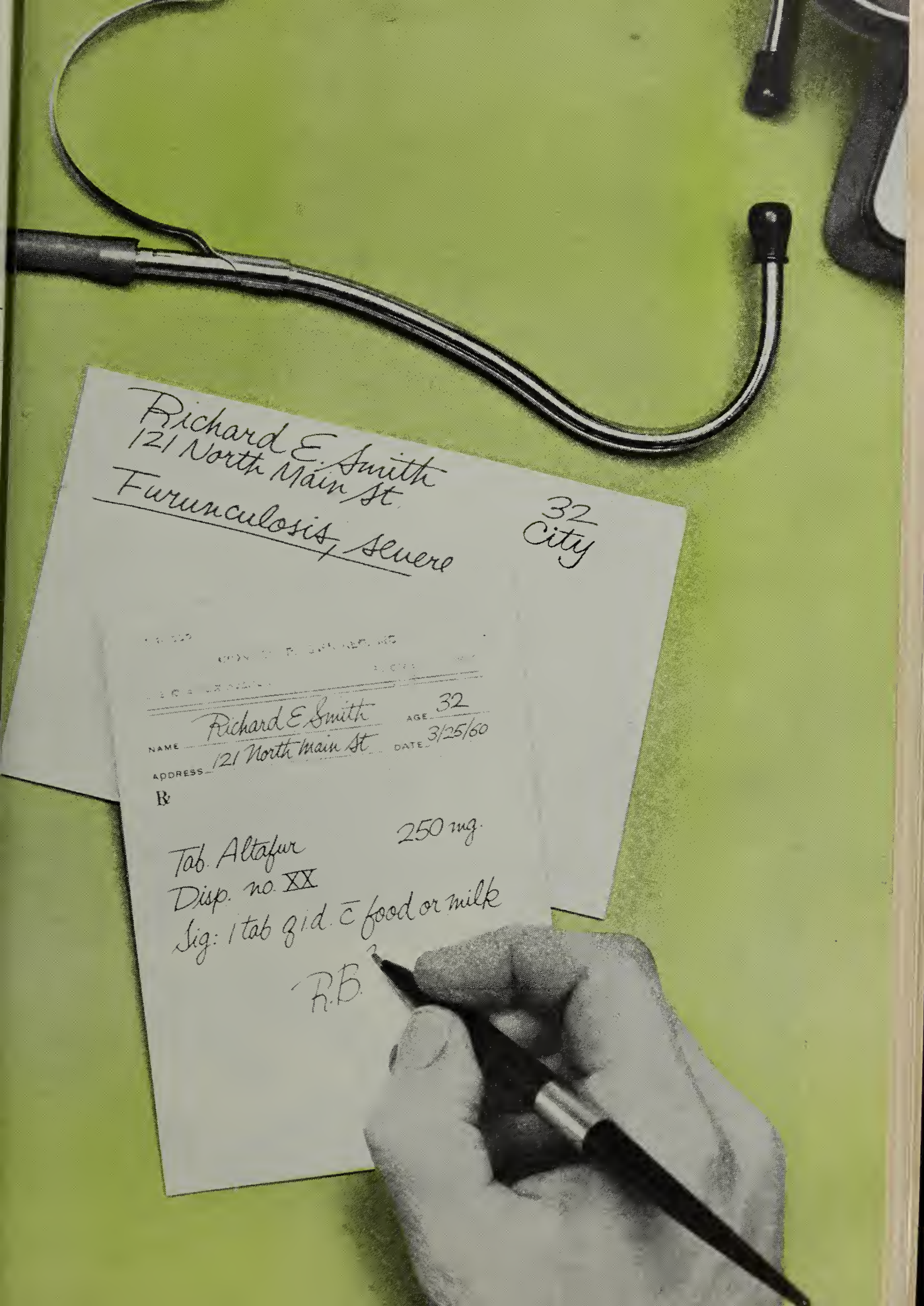
Blood coagulation. (*Schematic representation of current concepts of coagulation followed by many useful tables on coagulants and anticoagulants giving doses, actions, side-effects, hemodynamic effects, etc.*)

Effect of inorganic ions on the heart of man.

Congenital malformations of the heart. (*Summarizes occurrence of murmurs: roentgenographic, electrocardiographic, and hemodynamic findings: and prospect of surgical improvement.*)

In addition, there are numerous summaries on hemodynamics and blood composition in various diseases and conditions including shock, anemia, hypoxia, hypercapnia, endocrine disorders, and pregnancy.

(*Continued on page* 60)


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The index is excellent and makes it simple to find data on any specific point, and the table of contents lists the various subjects covered.

David P. Earle, M.D.

THE TRIUMPH OF SURGERY. By Jurgen Thorwald. 454 pages, 55 illustrations. $6.50. New York, Pantheon Books, 1959.

Breakthroughs in surgical technique and extension of the surgical approach to areas previously considered inaccessible to surgery are the subject matter of this historical account, which covers the period from 1881, year of the Third International Medical Congress in London, to 1906. Developments are traced chiefly through the narrator's personal observations and his interviews with the men who led the parade.

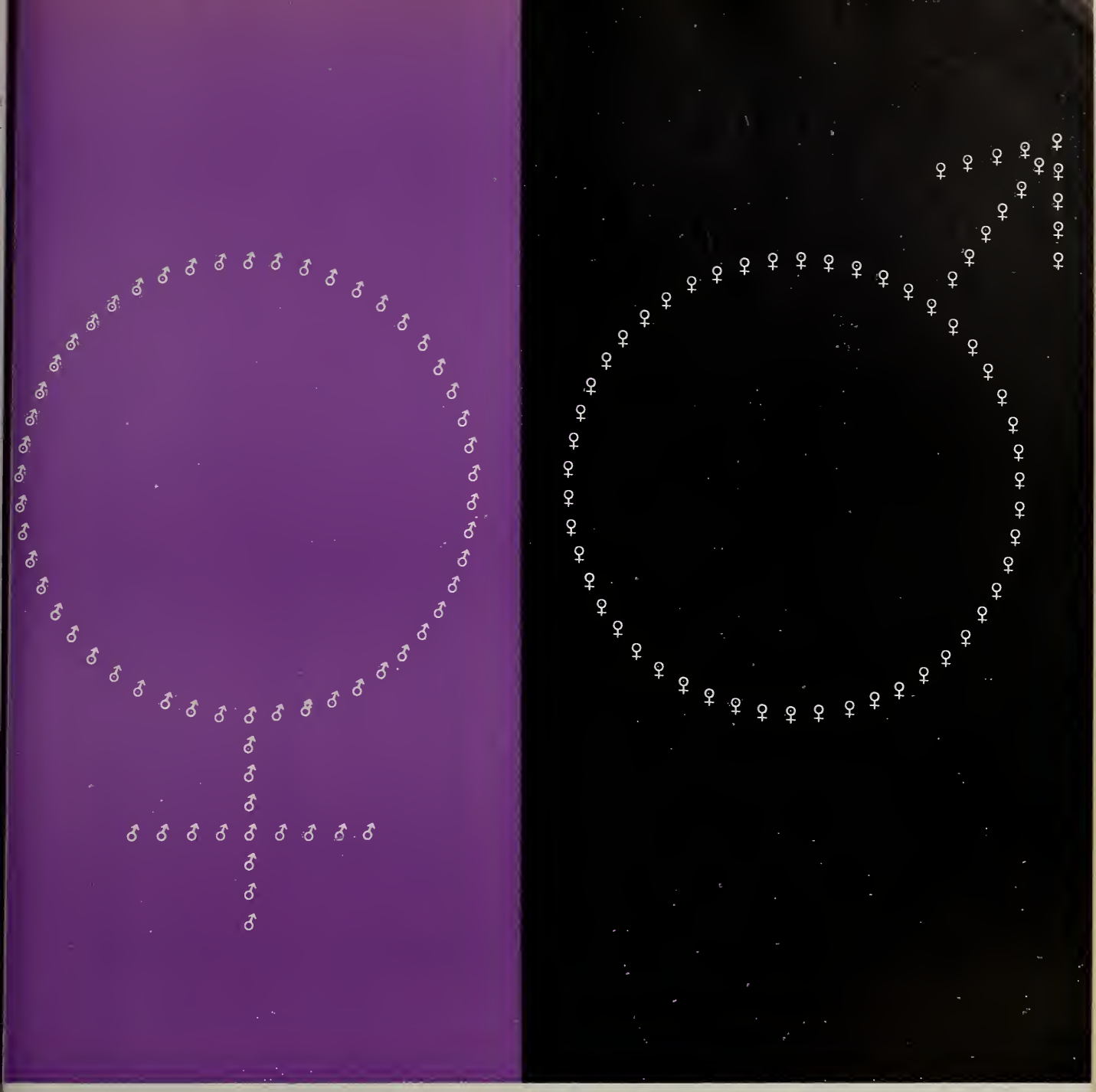
If the reader can overlook the improbability of the basic premise that the narrator, a non-practising physician, spent his time scurrying about Europe and England to catch the latest surgical procedure as if it were a new night club act, then much of this episodic account is very entertaining. Written for the layman interested in medical history, it presents significant developments in dramatic, easy to follow fashion. While it is possible that in that more leisurely era people may have been as verbose as they are here depicted, the narrator's redundancy in describing his own reactions slows the pace at times to a crawl.

In two or three episodes, notably those dealing with Kocher's early thyroidectomies and with the fatal illness of Emperor Frederick III, the author has managed to produce believable, lively characterization which is understandably absent from his portrayals of the hallowed participants in some of the other events reported. The fairly free display of personal animus which would seem to have characterized presentation of conflicting claims at surgical meetings and the heated nature of debates which leaked into the public press are amusing to a present-day reader unfamiliar with the free-wheeling attitude of nineteenth century surgeons toward public exposition of their controversies.

The volume is well organized, with a comprehensive list of sources, an index of names, and a bibliography of 508 titles.

Walter W. Carroll, M.D.





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*Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

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How can the speeding driver be reached? There is one slogan which is proving effective, one to which drivers, whether they consider themselves average or above average, are paying careful attention. That is the slogan of the State of Connecticut: *"Don't Speed—Save Your License."*

In Connecticut, drivers convicted of speeding automatically lose their licenses. The Nutmeg State has proved that while a driver will not slow down to protect a life, including his own, he will slow down to protect his license. The Connecticut experience has been so favorable that New Jersey has adopted similar legislation, and Pennsylvania and California are considering doing the same.

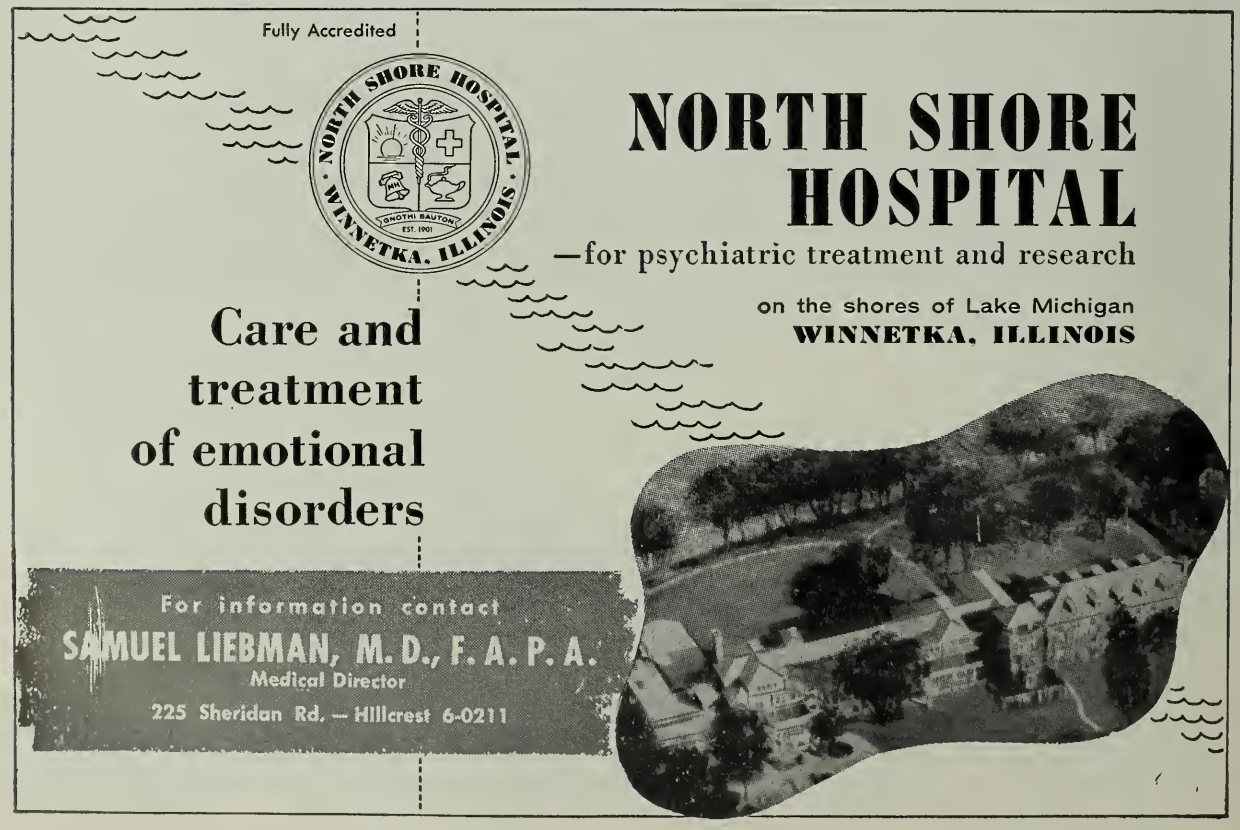
As a result of the Connecticut law, highway deaths in that state have been cut to one-half the national average. In 1955, the year prior to Connecticut's anti-speeding campaign, 325 persons lost their lives in highway accidents. Three years later (1958), with thousands of additional cars on Connecticut's improved highways, the total dropped to 251. *Save Your License. Mass. Physician. Dec. 1959.*

Esophageal pain

Esophageal motility studies are particularly helpful in diffuse spasm of the distal esophagus, entirely different from achalasia, and characterized by enough substernal pain, as well as dysphagia and pyrosis, to make the differentiation from anginal pain quite difficult at times. The diagnosis of this type of spasm depends on esophageal motility studies and cannot be made by x-ray or esophagoscopy. There must be many patients with a presumptive diagnosis of angina, not proven by the usual studies, who really have diffuse spasm of the distal esophagus.

One more most helpful aspect of these relatively easily performed determinations of esophageal motility is in deciding whether or not many of the symptoms which we attribute to a hiatus hernia are actually due to it and in offering us help in prognosis after surgical repair of a hiatus hernia. *Editorial. The Esophagus Rediscovered. Connecticut Med. Jan. 1960.*

Undertake something that is difficult; it will do you good. Unless you try to do something beyond what you have already mastered, you will never grow.—Ronald E. Osborn



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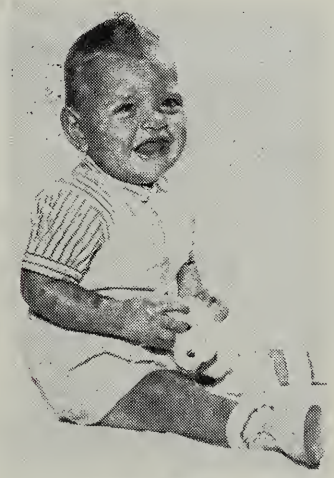
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Campaigns against behavior

A health education campaign in which the Edinburgh Public Health Department tried to bring home to the public the risks of lung cancer associated with cigarette smoking was evaluated by the Edinburgh University Department of Public Health and Social Medicine. The evaluation was based upon interviews with random samples of the adult population of the city—590 before the campaign and 596 six months later.

The campaign did not increase the proportion of non-smokers in the population, and the ratio of heavy to light smokers remained unchanged. Nor was there any significant increase in the proportion who believed that smoking may cause cancer of the lung. There was, however, a rise in the proportion who believed that smoking could be harmful to health in other ways—e.g., in causing cough—though these had not been mentioned in the campaign.

No change was evident in the nature and extent of smokers' ambitions to alter their own habits, but a greater proportion of those interviewed thought it undesirable that young people should start smoking.

About three in four of our informants reported having been aware of the campaign; newspaper articles and posters were the only publicity media frequently mentioned. Awareness of the campaign as a whole and of specific forms of publicity were found to vary with age, sex, and occupational class.

Campaigns of this type are unlikely to produce changes in behaviour except possibly in an indirect and long-term fashion. *Ann Cartwright and F.M. Martin, Ph.D. Efficacy of an Anti-Smoking Campaign. Lancet. Feb.* 6, 1960.

Serum cholesterol unchanged

A study of members of a religious group in this country who because of their religious beliefs subsist on a very low fat diet (about 30 grams a day) revealed serum cholesterol concentrations expected in individuals of the same age in the population at large. *Margaret J. Albrin, M.D. Usefulness of Serum Lipids in the Prediction and Treatment of Coronary Disease. Connecticut Med. Jan. 1960.*

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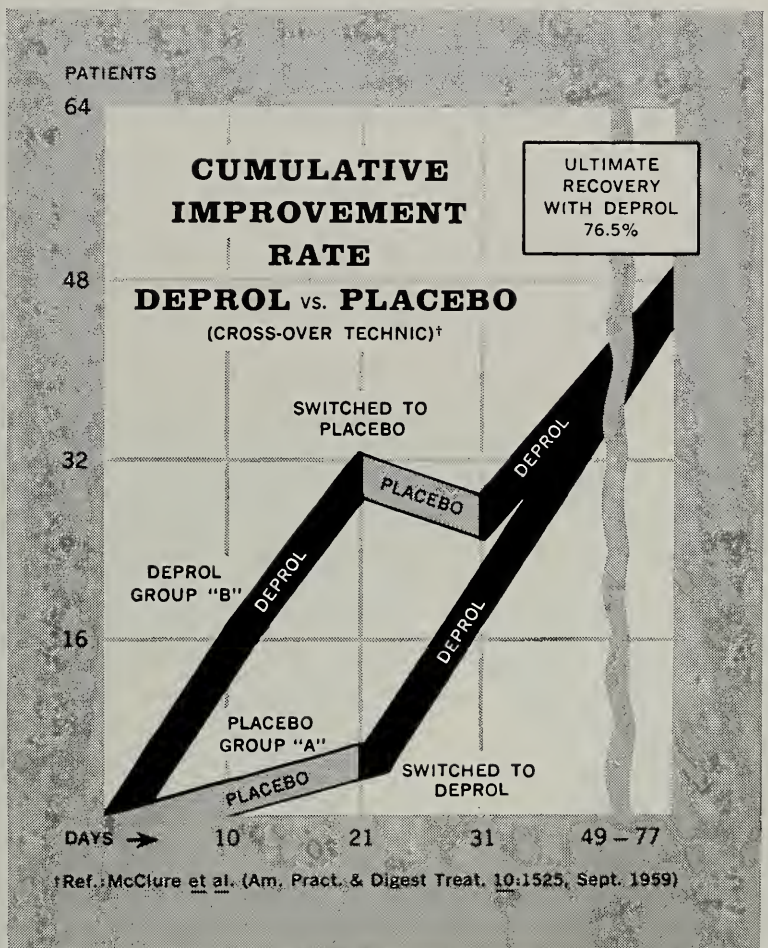
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BIBLIOGRAPHY *(11 clinical studies, 764 patients):*

1. Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **4.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **5.** Landman, M. E. (50 patients): Choosing the right drug for the patient. Submitted for publication, 1960. **6.** McClure, C. W., Papas, P. N., Speare, G. S., Polmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression—New technics and therapy. Am. Pract. & Digest Treat. 10.1525, Sept. 1959. **7.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **8.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **9.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **10.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination (Deprol). Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **11.** Splitter, S. R. (84 patients): The care of the anxious and the depressed. Submitted for publicotion, 1959.

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Colors fade, temples crumble, empires fall, but wise words endure.—Thorndike

Thymus follow-up

Thirty-two patients who received irradiation for suspected thymic enlargement in infancy between 1932 and 1950 are reviewed. Thirty-one of these have been traced. Three have died, one possibly from the acute effects of the radiation. One case developed a nodular goitre 22 years after the irradiation, another had slight diffuse enlargement of the thyroid at the age of 17, and another had a neurilemmoma removed from the neck at the age of 14. There were no cases of leukemia. *C. G. H. Newman, M.B. Long-Term Follow-Up of 32 Patients Irradiated for Thymic Englargement in Infancy. Brit. M. J. Jan. 2,* 1960.

Health through insight

The greatest resource for health is the attitude of the individual toward himself, developed through his own self-knowledge, through insights into himself, acquired usually with some pain over many years. *Editorial. James T. Heyl. M.D. Factors That Promote Health and Well-Being in Later Years. Geriatrics. Oct.* 1959.

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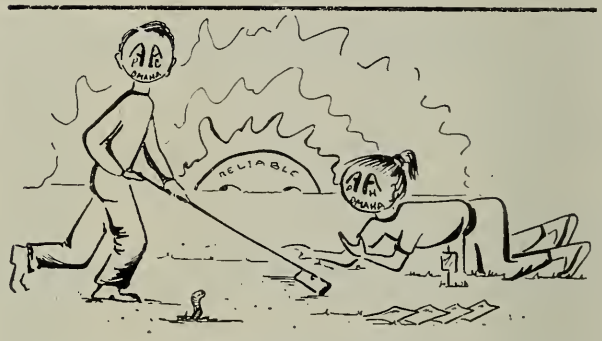
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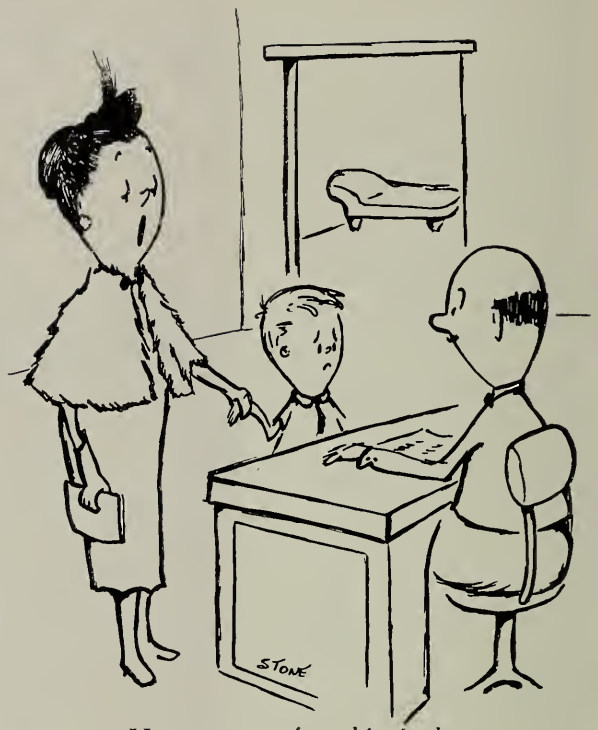
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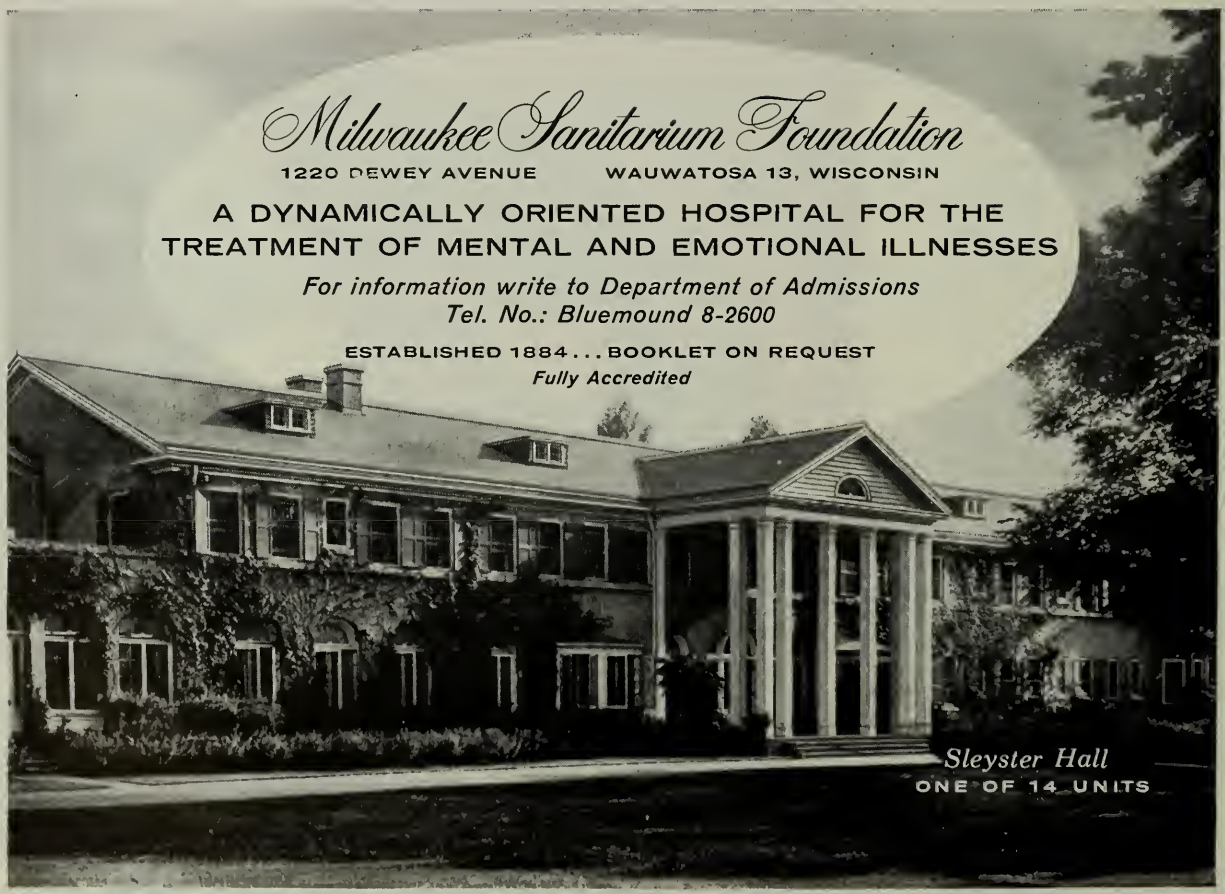
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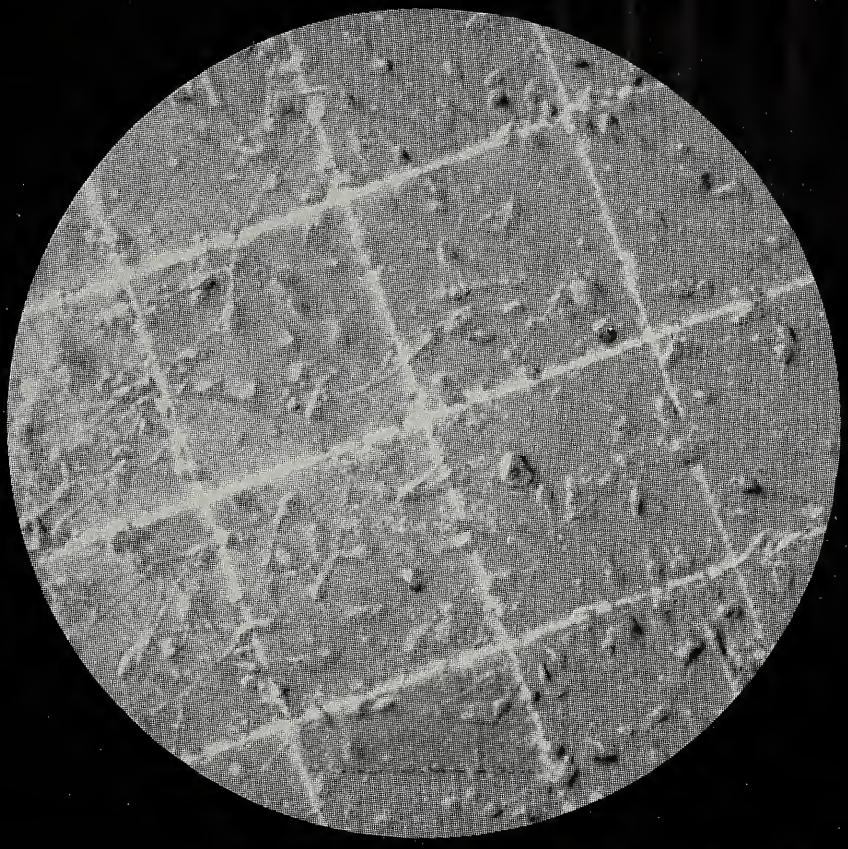
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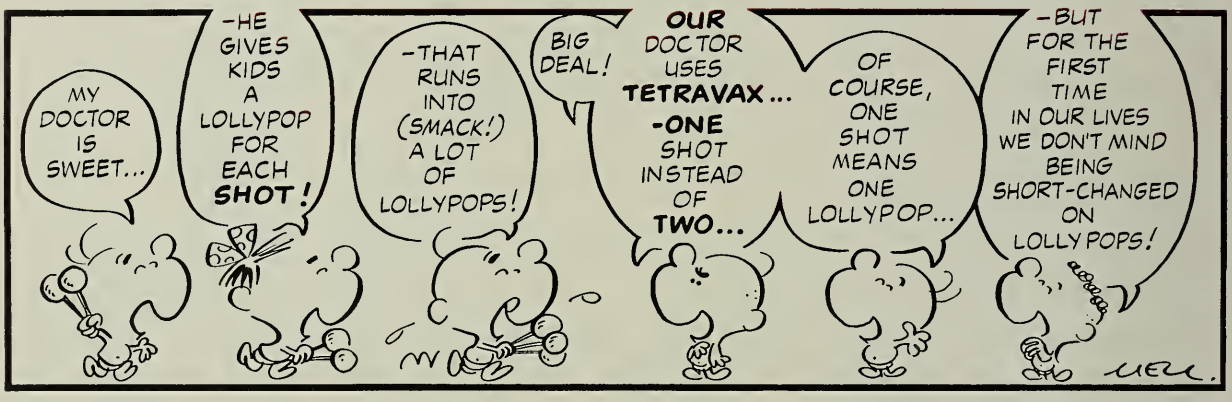
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TO 4-60

The Month in Washington



Politics now overshadows all other factors in the issue of health care for the aged. It appears certain to be a major issue in this year's campaigning for the White House and Congress, regardless of what Congress does in the field before adjourning this summer.

Both the Democrats and the Republicans are supporting costly, sweeping plans which differ on basic approach. Major Democratic plans call for the use of the Social Security System. The Republican proposals would have the Federal government and the states put up hundreds of millions of dollars to help the aged buy health insurance on a voluntary basis.

The medical profession and allied groups oppose these political solutions because, among other important reasons, they actually would not meet the problems of many aged who need help in financing the cost of illness.

Meanwhile, a key Democrat — Rep. Burr Harrison of Virginia — warned Congress against acting on such legislation in this national election year.

Noting various solutions proposed, Harrison said, "The only features which these proposals have in common are that they are all tremendously expensive; they all propose revolutionary change, and they are all complicated, uncertainly-based, and little-understood by the prospective beneficiaries."

Harrison, a member of the House Ways and Means Committee which handles such legislation, urged deferred action and recommended that the Ways and Means Committee "conduct an exhaustive study of the various proposals."

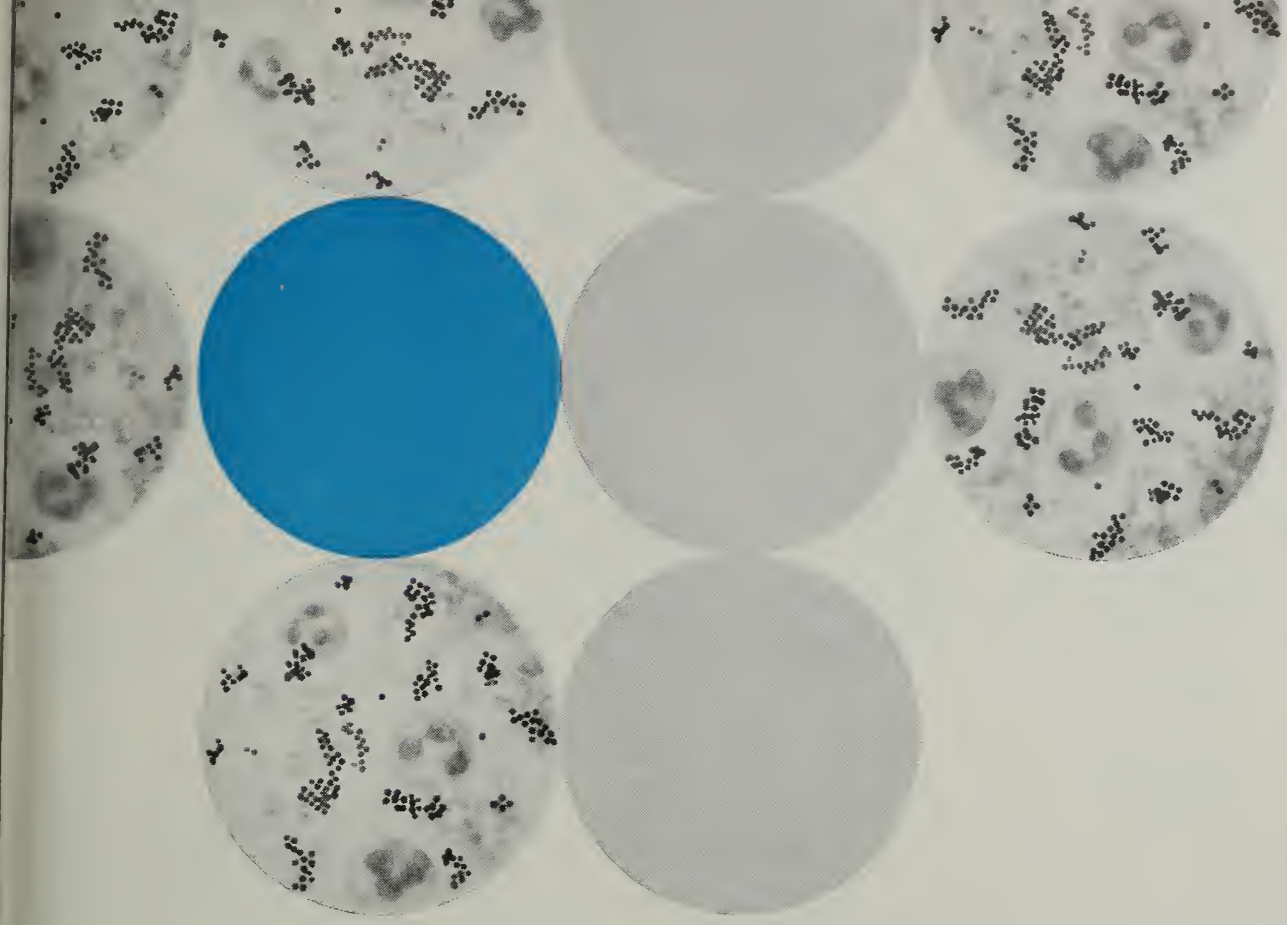
In early May the Eisenhower Administration unveiled a Federal-state, $1.2 billion-a-year plan to help the aged with limited incomes buy broad medical and hospital insurance coverage. Under the plan, an aged person — if able financially — would bear part of the cost of both the insurance and of the medical care and hospitalization.

Arthur S. Flemming, Secretary of Health, Education and Welfare, and Vice President Richard M. Nixon stressed that participation by the aged in the Administration program would be on a voluntary basis.

The Administration's plan immediately ran into widespread opposition. Dr. Louis M. Orr, Orlando, Fla., president of the AMA, said it was based "on the false premise that almost all persons over 65 need health care and cannot afford it. This is not a fact," he said. "The truth is that a majority of our older people are capable of continuing a happy, healthy, and, in many cases, productive life. Of the more than 15 million persons in the nation over 65 years of age, only 15 per cent are on old-age assistance." He said neither the Administration's proposal nor the Forand-type Social Security approach is tailored to meet the problems of the undetermined number of older persons who, "although able to finance other costs, find it difficult to withstand the additional burden of the cost of illness."

Dr. Orr advocated the AMA's positive eight-

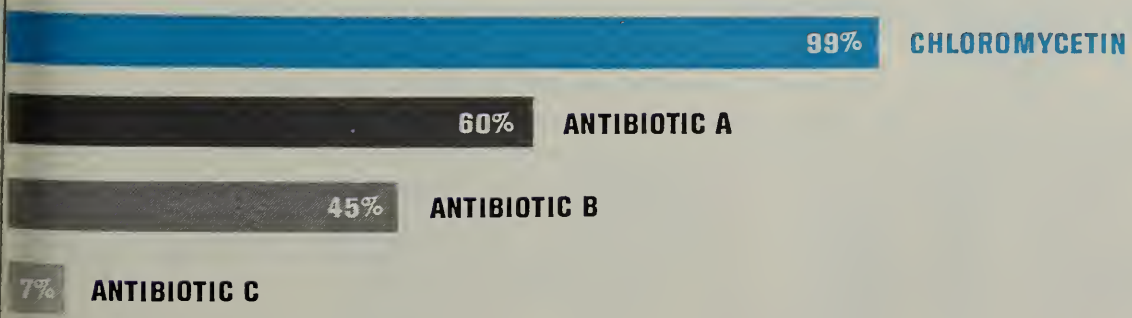
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*Adapted from Knight & Nolan[1]

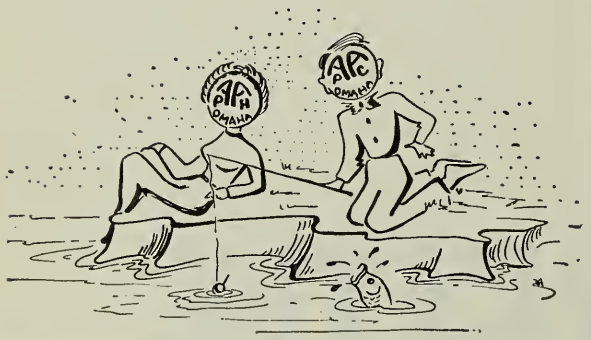
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WASHINGTON (Continued)

point program for the health care of the aged as a "sensible, economical" plan that would preserve freedom as well as promote security.

In brief, the AMA program comprises: (1) improved preventitive medical care for the aged; (2) a state-administered program of Federal grants-in-aid to states for liberalization of existing old-age assistance programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency; (3) better nursing home facilities for the long-term care of aged persons, especially those over age 75; (4) rapid development of health insurance and prepayment policies to provide long-term nursing home care; (5) expansion of home nursing care services; (6) elimination of compulsory retirement and a basic change in the attitude that a person who reaches 65 has suddenly become non-productive and senescent; (7) health education to instill a "will to live" in older persons and to make them aware of the need for continuing healthful nutrition; and (8) anti-inflationary curbs to maintain the purchasing power of fixed pension and annuity benefits.

Sen. Barry Goldwater (R., Ariz.), denounced the Administration's plan as "socialized medicine" and a "dime store new deal." The outspoken conservative predicted its ultimate cost would be "staggering." He said the Administration could have done better by proposing "full deductions for taxes for any amount spent for medical care of anyone" and for full costs of health plans by either an individual or corporation.

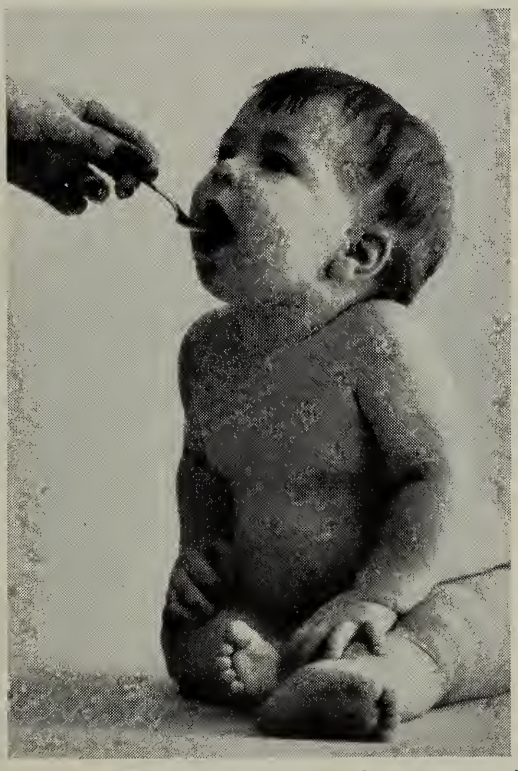
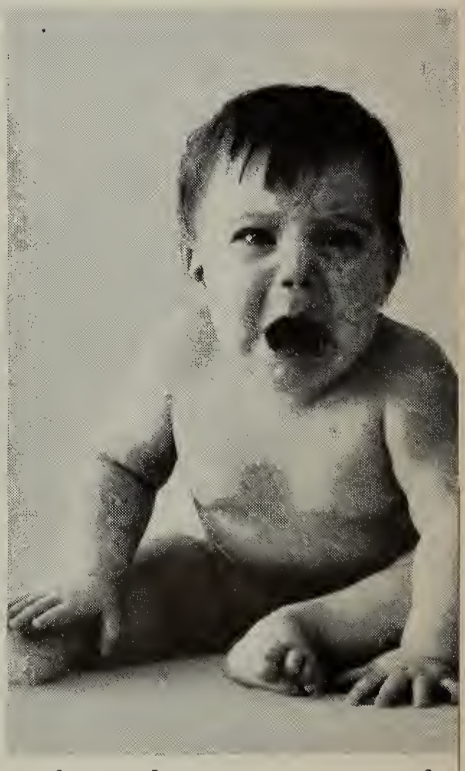
In endorsing the Administration's plan, Vice President Nixon charged the Forand-type proposals backed widely by Democrats would "open the door for socialized medicine. The Forand bill and similar plans," he said, "would set up a great state program which inevitably would head in the direction of herding the ill and elderly into institutions whether they desired this or not. Such a state program would threaten the high standards of American medicine."

Sen. Pat McNamara (D., Mich.), chairman of the Senate Subcommittee on Problems of the Aged, headed a group of 16 Senate Democrats who sponsored legislation that would provide hospitalization and medical care for virtually all the nation's older persons.





Just gotta reach that pencil. There! I'm so big. What can

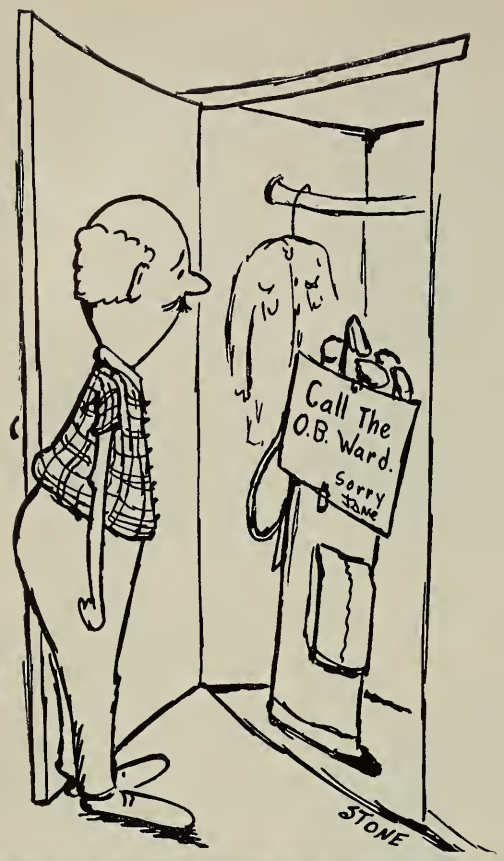
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Data now available demonstrate conclusively that Q fever occurs among dairy cattle in all parts of the United States. Bovine infections have been demonstrated in 35 states and have been found recently in all states where a concerted search has been made. Earlier studies indicated that bovine infections were frequent in seven states; namely, California, Wisconsin, Ohio, Iowa, Texas, Arizona, and Idaho. The current surveys in 26 States of 24,551 herds including 353,905 cows confirm and expand earlier findings in some areas and prove the occurrence of considerable bovine infection in 19 additional states—Oregon, Washington, Montana, Wyoming, Utah, South Dakota, Minnesota, Nebraska, Illinois, Michigan, Georgia, North Carolina, Maryland, Pennsylvania, New Jersey, New York, Connecticut, Massachusetts, and Hawaii. Other, more limited data suggest that bovine infection occurs in nine other states; namely, Louisiana, Mississippi, Virginia, Colorado, New Mexico, North Dakota, Kansas, Mis-



souri, and Kentucky. It is likely that infections occur in the remaining 15 unstudied states, most of which are adjacent to or surrounded by infected areas . . *Lauri Luoto, D.V.M., M.P.H. Report on the Nationwide Occurrence of Q Fever Infections in Cattle. Public Health Reports. February,* 1960. *Vol.* 75. *No.* 2.

Four score and twenty

According to the U.S. Bureau of the Census, there was in the United States in 1940 only 1 centenarian to 37,000 population or less than 3 per 100,000 population. Yet the number of centenarians in the United States rose from 3,679 in 1940 to 4,475 in 1950, an increase of 21.6 per cent, while in this same period, the total population of the United States increased by only 14.5 per cent. Estimates on the basis of spot studies indicate the number of centenarians will exceed 5,000 by 1960. *Belle Boone Beard, Ph.D. The Relation of Sociological to Biological Research in Gerontology. Geriatrics, October* 1959.

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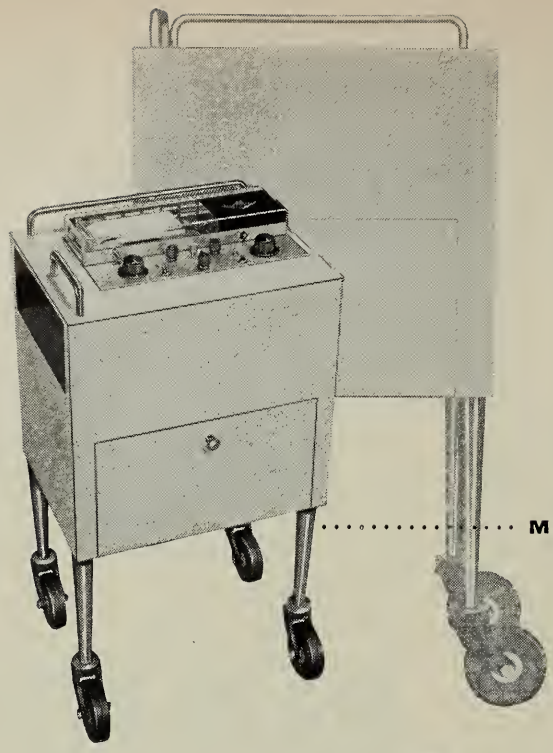
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1. Pomeranze, J. et al.: J.A.M.A. 171:252, Sept. 19, 1959. 2. Walker, R. S.: Brit. M J. 2:405, 1959. 3. Odell, W. D., et al.: A.M.A. Arch. Int. Med. 102:520, 1958. 4. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959. 5. Lambert, T. H.: ibid. 6. Skillman, T. G., et al.: Diabetes 8:274, 1959. 7. Sugar, S. J. N., et al.: Med. Ann. Dist. Columbia 28:426, 1959.



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The
ILLINOIS
Medical Journal
Official Journal of The Illinois State Medical Society

JUNE, 1960
VOL. 117, No. 6

Reminiscence*

Joseph T. O'Neill, M.D., *Ottawa*

The definition of the word reminiscence is "a mental impression retained and revived." I think this talk could also have a subtitle, and I would like to make that "Notes from the cuff of a drip-dry shirt."

Why did I choose a drip-dry shirt? Because it is so frequently washed, and many of the notes that were made on the cuff are lost in the process. But some of them are indelible, and no amount of washing erases them. It is of some of these notes that I wish to talk to you tonight.

As I see it, the president of this Illinois State Medical Society is an ambassador who represents you at all types of meetings and who endeavors to cultivate and cement your relations with many of the adjacent state medical societies.

When he speaks, he speaks for approximately ten thousand doctors in the state of Illinois. He does not make policy. Indeed, many times he is not consulted on policy. As far as policy is concerned, he simply carries out the directions of the House of Delegates and the Council. This fact I have realized, and I have tried to say and do the things during this past year which I thought you would like me to say and do.

Among the notes which have been inscribed on the cuff of the drip-dry shirt is one pertaining to this body, the House of Delegates. The delegate is really the liaison officer between the policy-making body of this society and the members of his county or branch society.

Misunderstandings of actions on the part of the House, and on the part of the Council as reported to the House, resulted among the members because of failure of the delegate to perform his function as a member of the policy-making body. To paraphrase Gertrude Stein, "a delegate is a delegate, is a delegate, is a delegate." You are a part of the system of communications which must be set up in the newly reorganized Illinois State Medical Society.

Many of you will undoubtedly recall that after I assumed the presidency of this body last May, I told you that it would be my endeavor during the year to develop and maintain a line of communications all the way down to each member of each component society. Failure of a delegate to function should be tantamount to the election of a new delegate at the county society level. Therefore, the responsibility for having a House, and an efficient House, depends upon the county societies' selections of the delegates as efficient members of that House.

The House should study efficient ways to improve itself. Actions should be taken by the House requesting that every resolution presented to the membership be either mimeographed, or printed in the handbook, so that each and every member considering any problem of sufficient importance to present in resolution form can can have a copy before him.

Reference committee members should be appointed early so that you may become familiar

**President's address delivered at the 120th annual meeting of the Illinois State Medical Society before the House of Delegates May 23, 1960.*

with who they are and with the matters they have to consider. This was done in part this year. Their names were printed in the Journal of the Illinois State Medical Society. This is a step forward, and in my opinion should be continued and improved upon.

Misunderstandings can spring only from misinformation, or lack of information. Such questions as have been addressed to the president of this society regarding Blue Shield Plans during the latter part of the year have practically all resulted from misunderstanding and apathy on the part of the members of the medical profession because they did not read the printed word.

It is rather pathetic to receive a communication from a large clinic group which is honestly bewildered by the turn of events because no one in the clinic group read the Council minutes printed in the March issue of the Journal.

This matter is further pointed up by the statement of a delegate at the special meeting of the House of Delegates last December. This delegate had not recently come to the House of Delegates. He has been a member for a long time. Yet he made the quoted statement: "Our Society is not like a corporation; the Council does not have to report to the House of Delegates. There is nothing mandatory for the Council but to exchange information." I think this statement should be reckoned with. I think a change in the Constitution should be made, that the Council should make certain reports to the House.

Does not the Council, and has not the Council for years made a report to the House? Does not each Councilor render a report of the activities in his councilor district to the House of Delegates? And is not this report published each year in the handbook? And is it not gone over by a reference committee? And is the report of the reference committee not received by the House, and examined or rejected? Does not the Chairman of the Council make a voluminous report to the House of Delegates of the activities of the Council? What more would you ask of the Council of this state medical society?

I have many indelible notes on the cuff of the drip-dry shirt. I sat on that Council for ten years, and for two of those years was its chairman. Not one of us is perfect. Not one of us can have consumate judgment. Not one of us is not human enough to err. But the time I spent on the Council of the Illinois State Medical Society is among the brightest of my memories.

Nowhere, but I repeat, nowhere, will you find a more dedicated body of men giving freely of their time, sacrificing a whole weekend at least seven times a year to talk over and to argue over many of the complexities of the practice of medicine which come before it. Mistakes may be made by any body of men, however dedicated. But mistakes made by the Council in my experience were mistakes of judgment, not of the heart because I feel that this dedicated body of men has well-being of the medical practitioners of Illinois in their hearts.

We have found in the last year that premeditated and well organized attacks upon American medicine have been formulated. We have found also that these attacks have not created the militant repudiation which I think they should have had. We are not organized to meet such a terrific propaganda onslaught because we perhaps have not fully realized the impact of these attacks.

It is only through you gentlemen that the rank and file of the Illinois State Medical Society can be militantly aroused to participate in this battle. And, oh what a chance we have to show proponents of the various health schemes what a militant, cohesive body can do!

The average doctor is a tremendous force in the thinking of his community. No matter what people ten miles away may think of him, his patients love him, and are guided by him. What will it require to make us take off our coats and get into this fight with a uniformity of purpose with a cohesion of mind which cannot be stopped?

Our opponents have many chances to get at us. They can be defeated and come back again and again and again. We have only the one chance. If we lose it, I can see no chance of erasing the law from the books.

"When the thing seems lost, earth holds no sorrow more acute."

I have tried to tell you of some of the notes indelibly written on the cuff of the drip-dry shirt. They have been indelibly impressed on my mind also. I shall cherish for the rest of my life the opportunity which was given me to head this fine body of men dedicated to the betterment of humanity. I shall forever remember the indelibility of the notes on the drip-dry shirt. Will you?

Calcinosis Cutis

Report of a Case in a Child

R. E. Dukes, M.D.* and
T. D. Swafford, M.D.**



Figure 1. Note nodules on thumb, index, and middle fingers of both hands of a 12-year-old girl with localized metabolic calcinosis cutis.

Calcinosis cutis is a descriptive term applied to the deposition of calcium salts in the skin and in the subcutaneous and interstitial connective tissues. Based on pathogenesis, two forms of calcinosis cutis exist: metastatic and metabolic. The former develops as a result of hypercalcemia, which may be due to (1) parathyroid neoplasm, (2) vitamin D intoxication, (3) chronic renal disease, or (4) bone destructive diseases. Metabolic calcinosis results from local metabolic derangements and is not associated with hypercalcemia.

Wheeler et al[1] distinguish two types of metabolic calcinosis: (1) dystrophic calcification (associated with localized injury), and (2) calcification secondary to tissue damage produced by one of the "collagen diseases," including scleroderma and/or Raynaud's syndrome, dermatomyositis, lupus erythematosus, rheumatoid arthritis, acrodermatitis chronica atrophicans, and mixed collagen disease.

Wheeler and his associates contend that metabolic calcinosis is nearly always secondary to one of the "collagen diseases" and that the cause can almost always be found. Nevertheless, the case we report illustrates that the cause may remain an enigma, and, in spite of thorough investigation, such cases must be labeled as idiopathic.

Case Report

This 12 year old patient was first seen in our clinic on April 21, 1959. Birth and developmental histories were normal, and family history was non-contributory. In 1955 she had noticed hard, elevated, callous-like lesions on her thumb. These had become progressively larger, and she had developed similar lesions on her elbows, buttocks, and feet. In 1957 she had been put on a low-fat diet, but had not continued it because she had lost weight. An attempt to remove the lesions with cautery had been unsuccessful.

She was a well developed, well nourished girl, weight 80 pounds, height 57 inches, blood pressure 116/52. The significant findings were the numerous yellowish-white nodules on the tips of her right thumb, index, and middle fingers, the left thumb, index, and middle fingers. (see Fig. 1), left elbow, right buttock, and left foot. The veins over her abdomen were moderately

*From the Department of Pediatrics,
**From the Department of Dermatology, Carle Hospital Clinic, Urbana

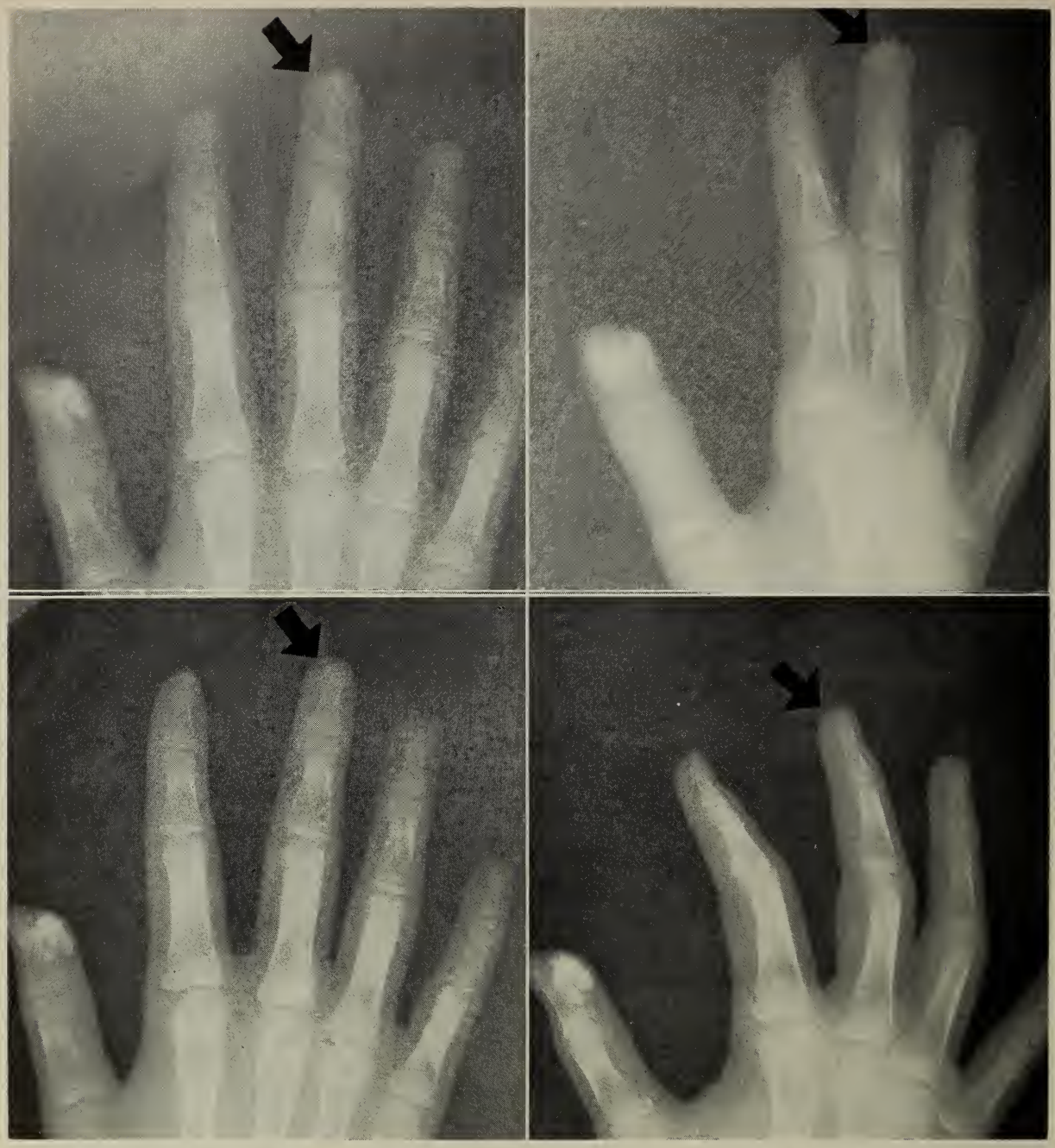


Figure 2. Roentgenograms (top) showing calcium deposits in soft tissue of affected fingers of left hand, and (below) after surgical removal from tip of middle finger. (AP and oblique views.)

distended, although her spleen and liver were not enlarged. Her heart had an irregular irregularity. Heart sounds were muffled but no murmur was heard. Examination revealed a marked myopia of the left eye; the fundi were negative.

Laboratory examinations showed urine with a specific gravity of 1.010, reaction alkaline; albumin, sugar, and bile negative; microscopic examination negative. The hemoglobin was 11.9 grams, erythrocytes 4,050,000, leucocytes 7,750, neutrophiles 62 per cent, lymphocytes 31 per cent, monocytes 4 per cent, eosinophiles 2 per cent, and basophiles 1 per cent. Blood urea was 20 mg. per cent; serum calcium 12.1 mg. per cent (which we consider within the upper limits of normal) or 6 mEq.; phosphorus 3.67 mg. per cent; bilirubin 0.1 mg. in one minute, total bilirubin 0.8 mg. Blood cholesterol was 170 mg.

per cent, alkaline phosphatase 2.93 Bodansky units. Kline and Kahn tests were negative. Bromsulphalein® dye retention for liver function showed retention of 1 per cent in 45 minutes. Total lipids were 260 mg. per cent, cholesterol 187 mg. per cent, of which 89 per cent was cholesterol ester, fatty acids 232 mg. per cent, lecithin, 117 mg. per cent, lipid phosphorus 6.8 mg. per cent, neutral fats were 0.0 mg. per cent. Urine creatinine creatine ratio: 58.0 mg./11.9 mg. (ratio 5 to 1.) The electrocardiogram showed ventricular extrasystoles.

Calcium deposits in the soft tissue of the distal portions of both thumbs, both index fingers, and both middle fingers were visible in roentgenograms. Figure 2 illustrates deposits on the left hand in roentgenograms taken before and after calcium had been removed from the tip of the left middle finger. A punch biopsy of the lesion on the right buttock on April 21, 1959, showed multiple granulomatous areas with extensive calcification in the upper and middle corium. On May 9, 1959, the calcium deposits were removed surgically from the tip of the left middle finger. Results were excellent, although the wound required several weeks to heal. If the deposits do not recur after several months, we plan to remove those from the other fingers.

Comments

The findings in either type of calcinosis cutis may be similar. However, in metastatic calcinosis the organs most commonly involved are the lungs, kidneys, and stomach, whereas the skin is only rarely affected. In metabolic calcinosis the deposits occur, as a rule, in the skin, only occasionally in muscles and tendons. Depending upon the extent of skin involvement, metabolic calcinosis is sometimes arbitrarily classified as circumscribed or universal. The universal type is more commonly associated with dermatomyositis, and the calcific infiltration is more likely to be diffuse. The circumscribed types are in general relatively benign. The lesions are hard, subcutaneous nodules of varying size, some of which may break down to discharge a chalky material containing gritty particles, and because they may suggest gout, give rise to the designation "chalk gout." Nodules are most commonly seen around the fingers, elbows, knees, buttocks, and shoulders, while the trunk, face, and scalp are usually spared.

Pathogenesis

Since there are no diagnostic clues other than the presence of calcium in the skin, the question of etiology leads only to clinical speculation. In addition to the collagen diseases, an underlying xanthomatosis has been considered as the etiology in idiopathic cases. Sutton[2] regards metabolic calcinosis as being closely related to xanthoma, because if the xanthoma lesions underwent calcification, the picture would be that of calcinosis. Without histologic confirmation, however, it would not be possible to prove such an association.

Among the collagen diseases, the calcification seen in scleroderma most closely resembles that described in most cases of idiopathic calcinosis cutis. Muller et al[3] recently reviewed the records of 381 Mayo Clinic patients with scleroderma of all types, seen from 1952 through 1956. Although there is no suggestion of scleroderma in idiopathic calcinosis cutis, the conditions share certain features. Muller's observations concerning calcinosis in the scleroderma patients also hold true for most cases of idiopathic calcinosis cutis: (1) no evidence of parathyroid disease, (2) predominance in females, (3) predilection for the upper extremities, particularly the hands. (4) calcinosis universalis rarely a sequela, and (5) relatively good prognosis. In all of the patients studied by Muller and associates, calcification developed after the onset of the scleroderma. It is impossible to predict whether or not a child with idiopathic calcinosis cutis is predisposed to develop scleroderma and/or Raynaud's syndrome, or some other collagen disease. However, it is evident that a life-time follow-up of such cases might provide valuble insight into the problem.

Local metabolic disturbance leading to calcification may result from the preferential binding of calcium ions by chondroitin sulfate, which recent studies show may act as a cationic exchange resin. [4-6]

Treatment

Many different forms of systemic treatment for removal of calcium deposits have been advocated, apparently with little success. There appears to be greater promise in the new chelating agent, ethylenediaminetetraacetic acid (EDTA). However, its use is by no means without hazard, which may preclude its use in the more benign type of calcinosis cutis without associated

collagen disease, if the condition is asymptomatic and not disabling, especially in children.

Davis and Moe[7] recently reported a case of severe and incapacitating calcinosis universalis of unknown etiology in a 12 year old female treated with Calcium Disodium Versenate® (EDTA). Dramatic results were obtained with no evidence of serious side effects, such as damage to the renal tubules or hypocalcemic tetany. They noted that the increased urinary excretion of calcium alone would not account for the remarkable degree of soft tissue decalcification. There is no doubt that use of a chelating agent is fully justified in cases exhibiting an extreme degree of calcification. Surgical removal may be resorted to in less severe cases, if ulceration is present or if the lesions interfere with function.

Summary

A case of localized metabolic calcinosis cutis in a 12 year old white female is presented. Differentiation of the various types of calcinosis cutis is discussed, and the importance of ruling out underlying collagen disease in metabolic calcinosis cutis is stressed. However, thorough investigation has revealed no evidence of associated collagen disease in the case presented. This fact indicates the desirability of prolonged follow-up of such patients in whom no etiological mechanism is apparent.

REFERENCES

1. Wheeler, C. E.; Curtis, A. C.; Cawley, E. P.; Grekin, R. H., and Zheutlin, B.: Soft Tissue Calcification, with Special Reference to Its Occurrence in the "Collagen Diseases," Ann. Int. Med. **36**:1050-1075 (April) 1952.
2. Sutton, R. L., Jr.: Diseases of the Skin, St. Louis, The C. V. Mosby Co., 1956.
3. Muller, S. A.; Brunsting, L. A., and Winkelmann, R. K.: Calcinosis Cutis: Its Relationship to Scleroderma, A.M.A. Arch. Dermat. **80**:15-21 (July) 1959.
4. Neuman, W. F.; Boyd, E. S., and Feldman, I.: The Ion-Binding Properties of Cartilage, in Fourth Conference on Metabolic Interrelationships, edited by E. C. Reifenstein, New York, Josiah Macy, Jr. Foundation, 1952, pp. 100-112.
5. Engel, M. D.; Joseph, N. R., and Catchpole, H. R.: Homeostasis of Connective Tissues, A.M.A. Arch. Path. **58**:26-39 (July) 1954.
6. Engel, M. B.; Joseph, N. R., and Catchpole, H. R.: Equilibrium of Calcium and Other Ions in Connective Tissues, in Metabolic Interrelations with Special Reference to Calcium, edited by E. C. Reifenstein, Jr., S. L. Wells, and B. B. Turner, New York, Josiah Macy, Jr., Foundation, 1954, pp. 105-118.
7. Davis, H., and Moe, P. J.: Favorable Response of Calcinosis Universalis to Edathamil Disodium, Pediatrics **24**: 780-785 (Nov.) 1959.

Successful psoriasis therapy

Whereas prednisone was of little value in psoriasis, triamcinolone often proved to be a valuable weapon in this recalcitrant disease. Our results in this study showed that approximately 30 per cent had a favorable response. Clearing of lesions, with less erythema and scaling, was usually apparent within five to seven days. The average daily maintenance dosage in this category was 8 mg. Interestingly enough, several cases failed to respond upon resumption of the drug after a relapse following cessation of therapy. One of our cases, a 43-year-old white male, was initially completely refractory to triamcinolone, but upon resumption two months later showed unquestionable benefit. Selection of psoriatic patients was restricted to severe chronic and rapidly spreading acute forms of the disease. *A. J. Edelstein, M.D. Triamcinolone in Dermatology. Pennsylvania M.J. December 1959.*

The highroad to atheroma

From all the evidence, it would appear that there are three major factors in the initiation and progression of coronary atheromatosis in young adults; namely, heredity, a high-fat diet, and emotional strain. Without exception, one or more of these factors were present in every patient in our coronary group, whereas none of these influences were observed in 24 per cent of the control subjects. At least two of the major factors were evident in 95 per cent of the coronary patients as compared with only 12 per cent of the control subjects. Emotional stress, usually associated with job responsibility, however, appeared far more significant in the etiologic picture of coronary disease in young adults than heredity, the quantity of fat ingested, tobacco, obesity, or exercise. *Burton L. Zohman, M.D. Emotional Stress and Coronary Heart Disease. Psychosomatics. January-February 1960.*

The Treatment of the "Untreatable" Patient*

Joseph B. Kirsner, M.D.† *Chicago*

". . . The glory of our profession is that we are interested not only in mankind, but in man."—T. C. Albutt

Twenty years ago a pharmacist with a depression and numerous complaints was dismissed by a psychiatric consultant as "untreatable." Since the symptoms were chiefly digestive, the patient sought medical attention in the gastrointestinal clinic. Many studies were normal. Therapy consisted of sedatives and antispasmodics and frequent visits with discussion of symptoms and the patient. For a long while there appeared to be no change, and the opinion of the psychiatrist seemed correct. Then the patient began to improve, almost imperceptibly at first, later more obviously. The visits became less frequent, and in time they ceased. The patient's symptoms had subsided; in addition, he had achieved recognition in his community as a useful citizen. Had he truly been untreatable? Or had he been difficult to treat?

Approximately fifteen years ago a patient with a history of alcoholism, malnutrition, and cirrhosis of the liver was hospitalized with ascites and thrombophlebitis of the veins in the abdominal wall. X-rays revealed not only esophageal varices but also a linitis plastica carcinoma of the stomach. When he lapsed into a confused state, the situation appeared hopeless indeed. It seemed only humane to grant the patient's plea for merely orange juice and coffee. To everyone's amazement, instead of deteriorating, he improved — without parenteral fluids, vitamins, antibiotics, or other modern therapeutic agents. The thrombophlebitis and the ascites diminished, and the patient returned home. We then learned that he had swallowed lye during childhood; the caustic undoubtedly had produced the gastric deformity simulating neoplasm. The patient survived for a considerable time, and occasionally revisited the clinic to demonstrate his viability. The hepatic disease eventually became "untreatable," and he died of cirrhosis; but had he been untreatable initially?

The word "untreatable" actually does not appear in Webster's dictionary; but Medicine always has recognized the obvious truth of Hippocrates' remark ". . . for it is impossible to make all the sick well . . ." Medicine also has made tremendous progress in reducing the ranks of the untreatable. Antibiotics, chemotherapeutic agents, hormones, isotopes, better understanding of body chemistry and nutrition, vaccines, anesthesia and remarkable surgical skills are some of the therapeutic achievements of the twentieth century. Many problems, of course, remain, such as the degenerative, neoplastic and metabolic diseases; and numerous illnesses of uncertain nosology, but, nevertheless, devastating effects. Perhaps, like the discovery of liver extract for pernicious anemia, insulin for diabetes, and vaccines for poliomyelitis, these problems also will yield to the intensive research now in progress.

The label "untreatability," therefore, is both absolute and arbitrary. Often it seems to be a relative term reflecting such factors as the cooperation of the patient or the limited knowledge of the physician rather than the illness itself. In an immediate sense, untreatability reflects the lack of a readily available solution. In a more ultimate connotation, untreatability is a function of time, awaiting the appropriate discovery, scientific revelation, or intuitive curative therapy. Untreatability is not always a product of scientific fact or diagnostic machine. Many gaps remain in our knowledge of medicine and in our understanding of man. Not infrequently the courageous patient, the dedicated physician, or the devoted nurse provides the vital spark, transforming an apparently hopeless situation into one of renewed health. Hope, faith, and persist-

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†Department of Medicine University of Chicago

ent therapeutic effort have salvaged many more sick people than we are accustomed to realize in this age of science.

This paper does not attempt to deal with all aspects of the "untreatable" patient, such problems as the hopelessly crippled, the pathetically retarded, or the economic and sociological impacts of the chronically ill upon our society. The patients comprising this series have been selected from recent clinical experience; some have kindly been suggested by colleagues. They are perhaps illustrative of certain accomplishments, but certainly not all; for the therapeutic dimensions of the "untreatable patient" probably have no absolute limitations.

Carcinoma

The following four cases illustrate the remarkable control of previously untreatable cancer now occasionally possible with surgical or medical hormonal treatment.

Case 1. Carcinoma of the Prostate with Metastases. A.J., aged 77, in 1939 underwent bilateral orchiectomy and vasotomy for carcinoma of the prostate with extensive osteolytic and osteoplastic metastases to the pelvis and femur. In 1940 a suprapubic prostatectomy was performed. Stilbesterol was prescribed daily. The original back pain subsided and the patient's health improved. From 1943 to 1953 there were practically no symptoms. X-rays in 1944 suggested a decrease in the metastatic lesions. In 1951 the roentgen appearance of the pelvis was unchanged. The patient finally succumbed to further extension of the carcinomatous metastases in 1953, at the age of 91.

Comment: The relatively simple procedure of orchiectomy and estrogens enabled this patient to live comfortably for 14 years. While no longer rare, control of metastatic cancer, even temporarily, remains a dramatic accomplishment, and holds promise of more complete control of cancer in the future.

Case 2. Ten-Year Control of Skeletal Metastases (Ca Breast). L.M.G., a 56 year old white housewife and lawyer, first noted a lump in one breast in 1935; the biopsy was interpreted as benign. Between 1935 and 1949 numerous examinations indicated benign nodules in both breasts. In 1949 x-rays, taken because of low back pain, revealed carcinomatous metastases throughout the pelvis and in the skull. The primary tumor was an extensive carcinoma of the breast. X-ray therapy (609 r) was directed to each ovary, and large amounts of testosterone were prescribed. Additional osseous metastases were observed in 1950. X-ray therapy now was directed to the cervical and thoracic spine and left hip. Between 1950 and 1953 metastases appeared to regress partially, and bone pain diminished. Between 1953 and 1959 the patient was free of symptoms, but in January, pain recurred in the left hip, and in June a pathological fracture involved the left clavicle. There were extensive metastases to bones, and a left pleural effusion had developed. Halotesten®, 20 mg. daily, was administered orally. In December 1959, because of numbness of the face, ascribed to neoplastic involvement of the fifth cranial nerve, roentgen irradiation was directed locally and methylprednisolone also was prescribed. Pain in both hips moderately incapacitated the patient. In March 1960 x-rays disclosed increasing metastases to the skull, spine, pelvis, and long bones. Adrenalectomy and hypophysectomy were under consideration as additional treatment. Meanwhile, steroids and androgens are being continued, and an additional 2000 r have been directed to the region of the left ischium.

Comment: This case illustrates the beneficial effects, albeit temporary, of androgens in a woman with metastasizing cancer of the breast. This remarkable lady's determination to maintain an active life has been inspiring. Until recently, she had continued successfully three careers: housewife, mother, and lawyer.

Case 3. Severe Asthma, Stenosing Duodenal Ulcer, Breast Carcinoma with Metastases. F.F., a 49 year old single woman, had a past history of x-ray irradiation to the thyroid at age 16, recurrent bronchitis with asthma, and peptic ulcer. In November 1955 she entered Billings Hospital for treatment of the duodenal ulcer and sinusitis. She was poorly nourished and in respiratory difficulty. Therapy with bronchodilators and expectorants was helpful. A bilateral mastectomy was performed for fibrocystic disease. The respiratory and digestive symptoms and a neurodermatitis were related by a psychiatrist to an emotional disturbance including a passive-aggressive personality. Supportive care and psychotherapy were effective temporarily, but hospitalization was required in May 1956 for recurrent respiratory difficulty that required

steroids and other measures. In 1957 ulcer symptoms increased and in May carcinoma of the breast necessitated right radical mastectomy. By January 1958 the stenosing duodenal ulcer had produced severe gastric retention. However, ulcer pain and the obstruction sudsided after prolonged hospital treatment with gastric suction and fluids parenterally. Because of a palpable mass in the upper abdomen, obstruction by tumor metastases also seemed likely. The outlook appeared very grave indeed, though the patient was never informed of this possibility. In March 1958 extremely severe respiratory difficulty again necessitated intensive treatment in the hospital, including prednisone. Ulcer distress increased, and in January 1959 an abdominal vagotomy and gastroenterostomy were performed. Many tumor nodules were present in the liver; microscopically these lesions appeared more sclerotic than the original breast carcinoma. A bilateral oophorectomy also was performed. After a long convalescence, the patient, instead of deteriorating as expected, proceeded to improve. Large amount of steroids now effectively controlled the asthma. She gained weight, her respiratory and gastrointestinal symptoms diminished, and by the end of 1959, she was sufficiently well to resume employment. In 1960 the patient is active and reasonably happy.

Comment: The combination of an obstructing duodenal ulcer, bronchial asthma with severe respiratory difficulty, and serious emotional difficulties might have overwhelmed a lesser person. The cancer of the breast with hepatic metastases should have been the final blow. Instead, successful surgical management of the ulcer permitted larger, more effective amounts of steroids to control the respiratory difficulty. Oophorectomy then inhibited progression of the carcinoma, at least temporarily. These individual therapeutic triumphs facilitated restoration of sufficient emotional stability, permitting return of this hitherto "untreatable" patient to an active life.

Case 4. Ulcerative Colitis — Carcinoma with Perforation and Metastases. K.F., a 36 year old male, developed ulcerative colitis in 1942. He responded to standard therapy, including bland diet, sedatives, sulfonamides, and vitamins. In 1949 symptoms increased after a period of physical and emotional tension. By April 1959 he had lost 30 pounds in weight and developed severe anemia; a large mass was palpated in the right lower abdominal quadrant. X-rays demonstrated a tumor in the ascending colon. At operation, a large carcinoma had perforated and was draining into the duodenum; the neoplasm extended through the wall of the colon. Metastases were demonstrated in two of nine mesenteric lymph nodes and in the wall of the abscess adjacent to the colonic-duodenal fistula. Postoperatively, considerable blood and plasma were required. The patient improved and eventually regained his normal weight. The course, subsequently, included a temporary iritis of the left eye, occasional joint pain, and mild symptoms of ulcerative colitis after physical fatigue or nervous tention. In June 1959 the hemoglobin was 13.1 Gm. In 1960 the patient is living a relatively normal life.

Comment: Carcinoma of the colon is more frequent in patients with ulcerative colitis than in the general population, and the neoplasm is more malignant than ordinary colonic cancer. By such evidence, this patient with metastases in lymph nodes and in the colonic-duodenal fistula should have succumbed long ago. Yet he survives 10 years after operation and is apparently in good health. This case, though not rare, does not represent the usual outcome. There is no satisfactory explanation for the patient's survival; but the extraordinary course emphasizes how much is yet to be learned of the biology of cancer.

Hepatic Insufficiency, Coma

The following two patients indicate the hazards of prognostication, even in the obvious, critical situation of hepatic insufficiency and coma. Their recovery, in absence of such therapeutic agents as neomycin, arginine, and adrenal steroids, also is noteworthy.

Case 5. Ulcer, Cirrhosis with Varices, Hepatic Coma, Hemorrhages. L.K., a 74 year old male, had had a gastric ulcer in 1946 and in 1951 developed jaundice. A diagnosis of cirrhosis of the liver was made clinically and confirmed by liver biopsy. Hepatic function tests were compatible with cirrhosis; bromsulphalein retention was 22 per cent. In October 1952 the patient returned because of gastrointestinal

bleeding from esophageal and gastric varices, and ascites. He soon became irrational and lapsed into a semi-comatose state. The electroencephalogram demonstrated small abnormal waves, though not the characteristic delta waves. Antacid therapy and fluids intravenously, including large amounts of glucose, were helpful. The patient improved surprisingly and returned home after 31 days. In February 1953 he underwent surgery for a possible thrombosis of the splenic vein. No splenic vein could be identified, and splenectomy and ligation of the left gastric artery were performed. The patient then was quite well for nearly five years. He was re-hospitalized in 1958 and 1959 for mild upper gastrointestinal bleeding that responded to medical management. X-rays suggested a decrease in the size of the gastric and esophageal varices. In March 1960 the patient appeared well clinically, though the liver remained large and nodular, and bromsulphalein retention approximated 44 per cent. Therapy consists of bland diet and antacids between meals.

Comment: Though this patient with obvious hepatic insufficiency was not in severe coma, his recovery, nevertheless, seems remarkable. Of interest also is the apparent decrease in the size of the esophageal varices roentgenologically. Thus far, he has not experienced recurrent gastrointestinal bleeding. His activity at the age 74 seems unimpaired.

Case 6. Cirrhosis of the Liver, Ascites, Hepatic Coma. G.O., a 62 year old lady bartender, had taken large amounts of alcoholic beverages and erratic quantities of food since 1935. In January 1945 she became ill with jaundice, nausea and vomiting, and a weight loss of 50 pounds. Persistence of the jaundice and development of ascites led to a diagnosis of portal cirrhosis of the liver. Between January and October 1946, she underwent approximately 15 abdominal paracenteses in unsuccessful efforts to control the ascites. She entered Billings Hospital in October 1946. The removal of approximately 12 liters of fluid by paracentesis was followed by the development of a tremor and confusion progressing to coma. The clinical situation deteriorated steadily, and all hope was abandoned. However, the hospital staff maintained therapy with plasma, blood, vitamins, glucose, choline and diuretics. The patient began to improve and then made a remarkable recovery, manifested by gradual subsidence of jaundice, ascites and edema. Hepatic function improved; the cephalin and thymol flocculation tests became negative. Plasma proteins improved from 5.4 Gm. per cent total (albumin 2.0 and globulin 3.4) in 1946 to 7.2 Gm. per cent total (albumin 4.6, globulin 2.6) in 1949. Bromsulphalein retention decreased from a range of 50 to 60 per cent in 1946 to 15 percent in 1952. The patient maintained a diet high in carbohydrates and vitamins, moderate in protein, and low in fat; and she apparently avoided the use of alcohol. In June 1952 her principal medical problems were obesity, diabetes mellitus, and hypertension. Nevertheless, she has remained in satisfactory health, as reported March 1960.

Comment: This patient was more critically ill than the preceding one, and her recovery seems all the more remarkable. Her survival 15 years later, despite obesity, diabetes mellitus, and hypertension, also is noteworthy.

Unusual Diseases

The following three patients had unusual and progressive illnesses. In each instance desperate therapeutic measures proved successful, though the nature of the disorder remained obscure. "Defeatism" and under treatment are as lamentable as overtreatment, and under certain circumstances, a more grievous error.

Case 7. Carcinoma Breast, Dermatomyositis — Dramatic Control after Adrenalectomy. P.G., a 51 year old housewife, underwent a radical mastectomy for carcinoma of the left breast in February 1954. X-irradiation was directed to the chest and axilla (7200 r) and to the pelvis (1300 r). Development of pruritic, erythematous rash and myalgia heralded onset of an extensive dermatomyositis. The 24-hour output of creatinine in the urine was greatly elevated (29.2 mg.). Other problems included hepatomegaly, anemia, hypochloremia, and hypernatremia, generalized loss of hair, congestive heart failure with pulmonary edema, muscle wasting, and contractures of the limbs. ACTH and testosterone were not helpful. The patient was helplessly bedridden and all therapeutic efforts were futile. In July 1954 a bilateral adrenalectomy was performed "as a last desperate effort." Cortisone was administered postopera-

tively. Rather than succumbing to the overwhelming problems, the patient improved. Convalescence was complicated by innumerable abscesses at the sites of needle injections and by thrombophlebitis. A high-protein diet and physiotherapy decreased the muscle wasting. After 409 days of continuous hospitalization, the patient was discharged on supportive treatment, including prednisone, 50 mg. daily, and testosterone. She was at home one year, and became able to perform light housework. In July 1956 hospitalization was required for an intratrochanteric fracture of the left femur and for the management of diabetes mellitus. The hepatomegaly was unchanged, and the dermatomyositis had not progressed. Because of significant amounts of estrogen in the urine, a bilateral oophorectomy was performed in September. The enlarged liver did not contain metastases. Therapy subsequently included insulin and hydrocortisone. In November 1959 Doca® and ascorbic acid were added to the program. X-rays revealed generalized osteoporosis and collapse of the centrum of lumbar I. The patient has maintained her remarkably favorable response. The appearance of the skin has improved tremendously. The principal finding now is mild weakness of the shoulder and girdle muscles.

Comment: Adrenalectomy probably rescued this patient from certain death. The beneficial effect remains unexplained, since in a second patient with dermatomyositis, adrenalectomy was not helpful.

Case 8. "Pseudohemophilia" — Uncontrollable Gastrointestinal Hemorrhage — Desperate but Successful Gastric Resection. L.T., a 47 year old woman, had manifested a tendency to abnormal bleeding throughout her life, especially at the menses, postpartum, following cuts and after dental extractions. In 1930 the spleen was found to be enlarged. Bleeding time was prolonged; clotting time and platelets were normal. Between 1930 and 1939 numerous hospitalizations were required for blood transfusions. The diagnosis of "pseudohemophilia" was considered in 1951 and 1953. In 1954 studies were considered compatible with van Willebrand's hereditary hemorrhagic desease. The paternal grandfather, a brother, and a niece had had bleeding tendencies. One sister had died at three months of age and another at 24 years of age from excessive hemorrhage. In 1954 a massive hemorrhage from the upper digestive tract subsided during antacid therapy. In November 1956 massive gastrointestinal hemorrhage was of such magnitude as to require 9,000 cc. of blood to maintain blood volume, at least temporarily. The hemorrhage continued, and, despite the hazardous bleeding tendency, operation was undertaken in a desperate effort to locate and perhaps remove the source of hemorrhage. A subtotal gastrectomy was performed; hemorrhagic gastritis was demonstrated histologically. To everyone's amazement, the patient recovered. However, in February 1957 she developed serum hepatitis, a left subphrenic abscess, and an abscess in the lower lobe of the left lung. This second critical situation was treated with large amounts of penicillin, streptomycin, and Achromycin®, again with a striking and unexpected respones. Between 1957 and 1959 the patient improved steadily. In November 1959 the red blood cell count and hemoglobin were normal. Although the underlying hematologic defect probably is unchanged, there has been no further bleeding.

Comment: This patient with a life-long unusual bleeding tendency survived two critical illnesses (a) exsanguinating gastric hemorrhage necessitating subtotal gastrectomy under desperate circumstances; and (b) the subphrenic and pulmonary abscesses responding to very large quantities of antibiotics. The "spontaneous" subsidence of the bleeding tendency remains an intriguing mystery. This case illustrates the occasional striking success of intensive and persistent therapy, even though the nature of the problem remains obscure. Such efforts would not appear justifiable in the transient restoration of the hopelessly diseased; but they are obviously worthwhile when they permit the return of the patient to an effective and useful life.

Case 9. Unexplained, Unresponsive, Prolonged Febrile Illness. D.J., a 60 year old Mexican laborer, had a past history of malaria and syphilis. In July 1959 he became ill with fever, chills, slight cough, and back pain. The leukocyte count and many laboratory tests were negative. The temperature continued at approximately 105°F., despite treatment with large amounts of penicillin, streptomycin, erythromy-

cin, Chloromycetin®, vancomycin, and sulfonamides. The course was complicated by massive hematemesis requiring four blood transfusions. He was admitted to Billings Hospital in September 1959. The principal physical findings were stupor, a Corrigan-type pulse, and pulmonary findings of pneumonia of the right lung. The leukocyte count ranged from 11,300 to 14,400. The hemoglobin was 9.7 Gm. and the red cell count 2.5 million. The blood sugar was elevated and reducing substances were present in the urine. The feces initially yielded strongly positive reactions for occult blood and later became negative. The serum albumin was reduced; the serum electrolytes were normal; and tests of hepatic function were normal. X-rays of the chest indicated pneumonia. A lumbar puncture was normal; the colloidal gold curve was 2433-210000.

The many diagnostic possibilities included meningo-vascular syphilis, syphilitic aortic insufficiency with subacute bacterial endocarditis, pneumonia, subdiaphragmatic abscess, respiratory or gastrointestinal neoplasm, blood dyscrasia, and various infectious diseases. The large number of bacteriological studies included blood cultures, cultures of spinal fluid, urine, feces, bone marrow, and sputum. Specific tests were made for malaria, brucellosis, tularemia, toxoplasmosis, leptospirosis, typhoid fever and infectious mononucleosis. Aerobic and anaerobic techniques and other diagnostic methods were utilized, with negative results. Multiple consultants were unable to clarify the cause of the persistent fever. The temperature appeared to decrease after the addition of Furadantin®, prescribed for mild urinary infection. The temperature again rose, and the patient's condition deteriorated steadily. Abdominal exploration was planned to locate a possible intra-abdominal abscess or neoplasm. Then, because of the presence of monilia in the sputum, Mysteclin® was added on the eighteenth hospital day; there was no significant change. However, when the dosage of Mysteclin was tripled, the temperature decreased and gradually returned to normal. The patient was discharged on the 45th hospital day, after 17 days of normal temperature. He remains well at present.

Comment: The cause of this febrile illness remains obscure. Recovery seems related, at least chronologically, to the administration of an antifungal antibiotic (tetracycline and Mycostatin®). This successful intuitive therapy obviated a hazardous and possibly fatal operation.

Erroneous Diagnoses of Cancer

The following two summaries illustrate the familiar problem of misinterpretation of physical, laboratory, or roentgen findings. Clinical evidence for "untreatability" because of cancer seemed conclusive in both instances; yet the initial diagnosis proved incorrect and the patients survive.

Case 14. Bullous Pemphigus, "Ca" Lung. D.M.H., a 74 year old male, developed clear, soft bullae over the body, including the palms and soles in January 1958, following a respiratory illness. Microscopic examination indicated pemphigus. Adrenal steroids, initially methylprednisolone 60 mg. daily, retarded the formation of new blisters; a minimal effective dosage of 16 mg. per day was established. The patient developed severe "steroid diabetes" necessitating insulin. In November 1958, ACTH gel was administered intramuscularly, 80 units daily. Because of a steroid psychosis, the corticotropin was discontinued and prednisone was substituted. An abscess at the site of a previous herniorrhaphy responded to Albamycin®. In January 1959 he developed a cough. X-rays demonstrated extensive pulmonary lesions, interpreted by two physicians individually as metastatic bronchogenic carcinoma with cavitation. This diagnosis was noteworthy in that carcinoma of the lung is not unusual in patients with bullous pemphigus.

The patient's family was advised of the hopeless situation, and he was "given up for dead." However, he was far from that. The cough subsided, and the appetite improved. In March 1959 *x*-rays of the chest reportedly were improved. In June 1959, *x*-rays demonstrated a rather large thin-walled cavity with surrounding parenchymal infiltrate in the right upper lobe, "almost certainly active tuberculosis." The patient remained well, however. Medication consisted of ACTH, 10 units every second day, 15 mg. prednisone and 15 units of insulin per day. The pemphigus is controlled completely. In 1960, the patient, at the age 76, is active and amazingly well. The pulmonary lesion seems to be localized emphysematous blebs.

Case 11. "Carcinoma" of the Pancreas: with Intractable Pain — Duodenal Ulcer. A.J., a 62 year old photoengraver, in 1940 developed severe pain in the epigastrium and in the back, with nausea and vomiting. A diagnosis of gallbladder disease was made elsewhere. Operation demonstrated inoperable carcinoma of the pancreas, and the abdomen was closed. The pain increased and did not respond to numerous medications, including opiates, nor to paravertebral nerve blocks. The patient's appetite decreased and he lost much weight.

He then was referred to the University of Chicago for possible chordotomy to relieve the intractable pain. On the surgical service, the pain continued despite many drugs, including codeine and morphine, and was accompanied by severe vomiting. The observation of clear, watery-appearing emesis fluid containing large amounts of hydrochloric acid, directed attention to a possible ulcer, perhaps in association with the carcinoma of the pancreas. The intragastric instillation of hydrochloric acid reproduced the pain and vomiting, and x-rays demonstrated a large duodenal ulcer crater. The usual antacid program did not relieve the pain completely, and 4 Gm. calcium carbonate hourly day and night, large amounts of atropine sulphate, and frequent gastric aspirations were required. The patient improved, and the course appeared more compatible with a duodenal ulcer penetrating into the pancreas and causing pancreatitis.

The surgeon presumably had misinterpreted the inflammatory thickening of the pancreas as neoplasm. In August 1941 an appendectomy was performed for acute appendicitis, and the absence of carcinoma was confirmed. The duodenal ulcer recurred in 1943, requiring more careful medical treatment. Another recurrence in April 1944 was treated by supradiaphragmatic vagotomy; the output of acid decreased considerably. Because of duodenal narrowing and gastric retention, a gastroenterostomy was performed in June 1944. The patient recovered uneventfully, and, when last contacted in 1958, indicated that he had been in good health.

Comment: The relentless epigastric and back pain, anorexia, weight loss, and the mass in the pancreas at operation appeared to amply justify the diagnosis of pancreatic carcinoma. However, careful clinical observation demonstrated a penetrating duodenal ulcer, obviating an unjustified neurosurgical procedure, and ultimately indicating effective control of the ulcer.

Surgical Problems

The following two cases illustrate the favorable course of apparently untreatable, yet actually operable surgical cases.

Case 12. Cholecystectomy, Bile Duct Injury, Recurrent Cholangitis — Multiple Unsuccessful Operations. T.P., a 51 year old housewife, in 1948 underwent a cholecystectomy, complicated by injury to the common bile duct and bile peritonitis. Numerous operations were performed to correct the bile duct obstruction, including reconstruction of the duct and hepatico - jejunostomy, with Rous - Y - Puestow modifications. From 1951 to 1955 the patient seemed well. She then developed cholangitis with jaundice, and between 1955 and 1958 experienced multiple episodes, not controlled adequately by sulfonamides and Achromycin®, among other measures.

The patient was jaundiced; the liver was enlarged; the serum alkaline phosphatase, bilirubin, and cholesterol were increased. The 24-hour urine urobilinogen exceeded 13 mg. (upper limit of normal 3 mg.). Bromsulfalein retention approximated 58 per cent. In February 1958 abdominal drainage of an abscess in the right flank yielded hemolytic E. coli, Proteus, and alpha streptococci. In June 1958 another operative effort was undertaken to resolve the seemingly hopeless progression of the biliary obstruction. Multiple calculi were removed from the stenosed common duct, caused by stricture of the previously established choledocho-jejunostomy. The stricture was dilated, a Rous-Y conduit was reestablished and the T-tube was inserted into the common duct. The patient's recovery was rapid and striking. Biochemical improvement included a decrease in the serum bilirubin, alkaline phosphatase, and the bromsulfalein retention, and a return of the plasma proteins to normal.

In April 1960 the patient experienced a mild pain in the right upper quadrant with slight fever, but no jaundice. Symptoms responded promptly to Achromycin; and the patient again seems well.

Comment: Injury to the common bile duct at cholecystectomy is a dreaded, often irrepa-

rable, complication. The failure of previous operations by competent surgeons emphasized the magnitude of the problem. Yet the recurrent, progressive cholangitis justified another, albeit desperate, surgical effort, in this case with gratifying results. The surgical reconstruction seems to have been effective.

Case 13. Carcinoma of Uterus, Radium Injuries: Resection Bowel, Bladder, Uterus, Vagina. V.R., a 52 year old woman, was treated with radium in April 1956 for carcinoma of the cervix. In January 1957 she received additional radium locally and also deep x-ray therapy to the pelvis. Bloody diarrhea in April 1957 indicated the development of radiation proctitis. Other problems were pelvic and intraabdominal abscesses and partial obstruction of the small bowel by adhesions. The abscesses were drained, and portions of the rectum and rectosigmoid area were resected. In October 1957 a vesico-vaginal fistula and hydronephrosis developed. In December 1957, because of the radiation damage and extension of the uterine neoplasm, extensive surgery was undertaken: total hysterectomy, combined abdomino-perineal resection, resection of the vagina and the urinary bladder, sigmoid colostomy and establishment of a urinary ilial conduit and reconstruction of a small vagina, antibiotic controlled drainage from a perineal sinus. A diet high in proteins, calories, and vitamins facilitated recovery, and the patient gained in weight from 118 to 160 pounds. Indeed, her improvement was so pronounced that approximately two years later she married and reported satisfactory sexual relations. At present, she is well generally, but she has required isotopic treatment of a localized recurrence of cancer.

Comment: This case emphasizes the importance of well-directed radical cancer surgery. In this instance, untreatability reflected one surgeon's inability to deal with extensive cancer; but, in the hands of a more experienced surgeon, the situation actually was treatable. Though the patient is undergoing local treatment, her rehabilitation and subsequent marriage is a striking accomplishment.

Successful Avoidance of Surgery

In the next two cases surgical intervention seemed imminent and justified, yet proved unnecessary.

Case 14. Duodenal Ulcer with Obstruction. A. C., a 77 year old man, developed ulcer symptoms in 1932. In 1935 the ulcer had produced severe obstruction and gastric retention. Large amounts of food and fluid were aspirated from the stomach daily, despite a limited intake of food, and antacid therapy. An operation was strongly advised. The patient refused, however, preferring to continue medical management with daily gastric aspirations at home. Ulcer pain was relieved, but the retention persisted, with aspirates ranging in volume from 4 to 16 ounces up to one quart. The patient continued daily gastric aspirations until 1938. These were resumed periodically in 1940, 1947, 1948, and 1949, as he experienced fullness and gastric distention. Repeated x-rays demonstrated decreasing obstruction, but continued stenosis of the duodenal bulb.

In 1947 the channel through the duodenum appeared more patent. Mild ulcer symptoms in 1947 and slight gastrointestinal bleeding in 1949 responded promptly to renewed antacid therapy. The patient discontinued all medication in 1952, reporting, "I learned to take it easy." Except for moderately severe but uncomplicated hypertension, he remains well and active. X-rays in March 1960 demonstrated the usual ulcer deformity of the duodenal bulb without obstruction or severe stenosis.

Comment: The label of "untreatability" is applied often in ulcer therapy because of a common tendency to casual, incomplete treatment. In this case the judgment of the patient was hazardous, in view of the conclusive evidence of obstruction. Yet prolonged, careful ulcer management and time accomplished a rather striking therapeutic triumph. Undoubtedly many patients operated on for peptic ulcer would respond to careful, prolonged medical management, if they were willing to make the effort, as did this individual.

Case 15. Radiation Proctitis — Colostomy Planned but Cancelled — Response to ACTH, Steroids: — M. S., a 60 year old Negro housewife, in November 1953 underwent radium therapy for carcinoma of the uterus. In April 1954 additional x-ray was administered, 3,200 r to each parametrial area and 1,500 r to the perineum. A complete hysterectomy and bilateral salpingo-oophorectomy were performed in August 1954. Urinary distress and rectal bleeding

led, in March 1955, to diagnoses of radiation cystitis and proctitis. In April 1955 rectal bleeding was so pronounced that the hemoglobin decreased to 5 Gm. per cent; 3,000 cc. of blood were required to raise the hemoglobin to 11 Gm. Because of the friable rectal mucosa and a stricture at the rectosigmoid level, a colostomy was planned. However, as a final medical therapeutic effort, ACTH was administered in daily doses of 120 units. The diarrhea and rectal bleeding subsided dramatically. Hydrocortisone was substituted later, and a daily maintenance dose of 40 Gm. was established. Subsequently, the steroid was changed to prednisone, initially 50 mg. per day, decreasing to a maintenance level of 15 mg.

In November 1958, increased diarrhea and occasional rectal bleeding responded to hospitalization for 10 days, and therapy with a bland diet, sedation, and prednisone. Gynecological examination indicated no evidence of recurrence. A colon x-ray was normal. In April 1959, bowel function having been normal, steroids were discontinued. At present, the patient has no gastrointestinal complaints, though she is troubled with arthritis and hypertension.

Comment: Until the advent of ACTH and adrenal steroids, radiation proctitis was indeed an almost untreatable problem. Similar beneficial results have been obtained in other patients with radiation injury of the colon and rectum.

Case 16. Incapacitating, Post-Gastrectomy Dumping, Malnutrition. — M. J. S., a 41 year old woman, experienced ulcer symptoms in 1943. In 1949 a severe hematemesis required blood transfusions. In 1951 recurrent gastrointestinal bleeding culminated in a subtotal gastric resection. There has been no further bleeding. However, the patient developed extremely severe dumping, with postprandial nausea, pronounced weakness, and weight loss from 120 to 90 pounds. She was totally incapacitated and forced to remain in bed. In July 1951 she was placed on a program of frequent meals, separation of liquids from solid foods, and mild sedation. Symptoms subsided partially and she returned to work; but the dumping continued. In 1955 restoration of normal gastrointestinal continuity (Billroth I), eating meals in the recumbent position, and intramuscular administration of vitamin B_{12} produced further improvement.

Between 1955 and 1960, though the patient continues to eat usually in the recumbent position, she has maintained a perfect attendance at work and has gained weight. She credits a significant proportion of her recovery to the continuing encouragement of her physician.

Comment: The magnitude of the physiologic disturbance induced in some patients by subtotal gastrectomy often is not appreciated fully. This woman was a total invalid for almost one year and a semi-invalid for several years. While her improvement can be ascribed to the Billroth reconstruction, the recumbent position at meals, and perhaps to the support provided by her physician, the patient deserves much credit for her determined efforts to resume an active life.

Survival Despite Multiple Critical Illnesses

The next three cases emphasize the remarkable viability of some patients despite multiple critical illnesses.

Case 17. Peptic Ulcer with Hemorrhage, Arteriosclerotic Heart Disease with Coronary Insufficiency and Heart Failure, Diabetes, Urinary Obstruction, Pulmonary Lesion. D. K., a 76 year old man, had developed ulcer distress in 1923. Dyspnea, angina, and ankle edema appeared in 1938. He was treated at Billings Hospital in January 1953 for peptic ulcer with massive hemorrhage and coronary artery insufficiency. His course then was satisfactory for five years. In July 1958 severe chest pain recurred, accompanied by shock. The trachea was deviated to the left and breath sounds over the left chest were reduced. X-rays demonstrated a mass in the left hilus compatible with carcinoma; a shift of the mediastinum to the left, atalectasis of the left upper lobe, elevation of the left diaphragm, and a pleural effusion on the left. The diagnosis of bronchiogenic carcinoma was supported by cytologic interpretation of the sputum as strongly suggestive of malignancy. However, the patient improved on therapy including a low-salt diet, Digilanid® and nitroglycerin; and one week later the pulmonary abnormalities underwent remarkable resolution.

In August 1958 chest pain and extreme dyspnea recurred. X-rays indicated left pulmonary atalectasis and a shift of the mediastinum to the left. One week later there again was strik-

ing resolution; only the pleural effusion persisted. Bronchoscopy indicated narrowing of the bronchus to the left lower lobe and a possible carcinoma. Electrocardiograms were compatible with myocardial ischemia of the anterior wall. The patient required oxygen, among other therapeutic measures. His course was complicated further by prostatic hypertrophy and urinary retention necessitating an indwelling catheter. The left pulmonary atalectasis recurred, but once more subsided. The patient was hospitalized again in January 1959 because of congestive heart failure. The urine contained many white blood cells, and the leukocyte count was 38,000. The left diaphragm remained elevated. Again, symptomatic therapy proved effective. In may 1959 hospitalization was required for hemorrhage from the upper digestive tract and severe chest pain. In addition to antacids, sulfonamides, Digilanid, diuretics and potassium iodide, four units of packed red cells were administered. Because of a questionable mass in the fundus of the stomach, gastric cytology was performed, with negative results. In July 1959 hospitalization was required for treatment of a urinary infection. The patient, subsequently, has been surprisingly well with only occasional ankle edema. In March 1960 the blood count was satisfactory, his appetite was good, and the lungs were clear.

Comment: This patient was near death on at least three occasions because of coronary insufficiency, recurrent pulmonary atalectasis, and gastrointestinal bleeding. He remains remarkably alert and active despite the limitations imposed by his age and the multiple serious diseases.

Case 18. Multiple Major Diseases, Paralysis Phrenic Nerve, Septicemia. — H. C. A., a 58 year old lawyer with a history of hay fever and bronchial asthma, became ill in July 1957 with fever, cough and malaise. He was treated with antibiotics for pneumonia. Three days later, sudden shortness of breath, precordial pain, and rales over the lower lobe of the left lung led to a diagnosis of acute heart failure secondary to myocardial infarction. Penicillin, sedation, and an oxygen tent failed to relieve the dyspnea and cyanosis. Pericardial or pleural effusion was suspected, but a pericardial puncture yielded only a few milliliters of clear amber fluid. Bronchoscopy did not demonstrate obstruction. Digitalis and sedations were ineffective. A review of the problem led to diagnoses of asthma, atalectasis, pneumonitis, and right pleuritis. The occurrence of bloody stools and the demonstration of staphylococci in the feces indicated a diagnosis of enterocolitis probably caused by antibiotics. Intensified abdominal pain, nausea, vomiting, and diarrhea were treated with fluids intravenously and with erythromycin. The patient's condition now was critical and he was transferred to Billings Hospital.

The important findings were cyanosis, a purpuric rash over the face, arms and legs, paralysis and elevation of the right diaphragm, and fever. The stools were positive for occult blood. The total plasma proteins were only 4.6 Gm. per cent (albumin 2.3 and globulin 2.6 Gm. per cent). Bromsulphalein retention was increased to 24 per cent. Electrocardiograms were compatible with anterolateral myocardial infarction. Bronchoscopy did not reveal any abnormality. Cytologic study of fluid removed from the right chest was negative for malignant cells. A sharp rise in temperature to 39°C. prompted blood cultures, and these yielded Aerobacter aeruginosa; a similar organism was cultured from the indwelling catheter of the intravenous "cut down." The organism was sensitive in vitro only to polymixin B, but, because of potential toxicity, this drug was not prescribed. Remarkably, removal of the catheter and discontinuance of the ACTH were followed by subsidence of fever and disappearance of septicemia. Additional therapy included prednisolone, Gantrisin®, air conditioning of the room, and discontinuance of all other medication. The patient returned home after 34 days.

He improved gradually during the next two years, though the paralysis of the right diaphragm persisted. Remarkably, and without explanation, in 1959 the paralysis disappeared, and the diaphragm regained its normal position and mobility. At present the patient experiences mild asthma and fatigue. He is working part time as a lawyer.

Comments: This patient's course was remarkable in at least three respects: recovery from septicemia with Aerobacter aeroginosa, from very severe respiratory distress associated with asthma, and restoration of normal mobility of the diaphragm. The explanation for the prolonged paralysis of the phrenic nerve is not known. An important factor in the favor-

able course probably was avoidance of excessive medication.

Case 19. 20 Major Diseases. C. P. N., a 60 year old housewife, had had rheumatic fever at the age of 13 and an enlarged thyroid since childhood. Her past history included fractured ribs, a hysterctomy for fibroids in 1949, appendectomy, subtotal thyroidectomy for a nodular, non-toxic thyroid, hemorrhoidectomy, and repair of a rectal prolapse. Because of the x-ray demonstration of two polyps in the mid-transverse colon, she was examined repeatedly between 1952 and 1955. Apparent enlargement of the polyps and a large mass in the left upper abdominal quadrant necessitated operation in June 1957. Polyps were removed from the mid-transverse and sigmoid colon; a large pancreatic cyst was excised; and a cholecystectomy was performed for cholelithiasis. Additional diagnoses included arteriosclerotic and rheumatic heart disease, tenosynovitis of left thumb, and urinary tract infection. The postoperative course was complicated by congestive heart failure, but the patient recovered after several months.

In November 1957 she was hospitalized because of a recurrent pancreatic cyst causing intermittent intestinal obstruction and further complicated by acute pancreatitis. While operation was under consideration, the patient developed weakness of the right arm and leg, slurring dysarthria, and slight lower facial weakness, caused by arteriosclerotic thrombosis, presumably of a branch of the middle cerebral artery. Treatment included anticoagulants (heparin, Dicumarol); Digilanid, penicillin and streptomycin were continued. The patient's condition now seemed desperate; but with symptomatic care and physiotherapy, she slowly improved.

In December 1959 she experienced a sudden chill and pain in the right costovertebral angle. The temperature increased to 40°C., and the leukocyte count reached 45,000. The urine contained many leukocytes and erythrocytes; and the blood urea nitrogen rose to 47 mg. per cent. Blood and urine cultures yielded Aerobacter aerogenes. Diagnoses were acute cystitis and pyelonephritis, and septicemia. X-rays also demonstrated an obstructing calculus at ureterovesical junction on the right, and pneumonitis of the right lower lobe. The patient's condition again seemed desperate. Once more, however, she demonstrated remarkable viability, responding to chemotherapy with Gantrisin, Chloromycetin®, streptomycin and intravenous fluids; Digilanid was continued for the heart, and insulin for the diabetes. The patient subsequently has improved further. She is now able to walk with the aid of a cane. In May 1960, though physical activity remains limited and memory is faulty, this remarkable lady demonstrates a will to live and a determination to function adequately, far more effective therapeutically than many combinations of drugs.

"Functional" (Emotional) Problems

Patients with emotional difficulties and functional symptoms, though not necessarily confronted with physically critical diseases, present some of the most difficult therapeutic problems in medicine. However, the majority are not as untreatable as they may appear initially, provided an understanding and tolerant physician is willing or able to devote sufficient time to them. Certainly, not all emotionally disturbed patients require phychiatrists; the properly oriented internist can be as helpful, and in many instances, more effective.

The principles of therapy include thorough study and careful evaluation of the individual, a simple explanation of the nature of the symptoms that avoids criticism, ridicule or moralization; an opportunity for the patient to verbalize his conflicts, anxieties and frustrations; and the persevering, objective support and reassurance of the physician. Recent comments by Ross on the use and misuse of sympathy seem pertinent: ". . . But the rest of our patients, without exception, are in need of reassurance. The many who are not ill need nothing else; the gravely ill often can be afforded little else. . . . In medicine compassion complements competence; indeed, one can hardly exist without the other." Mild sedatives and antispasmodics may be helpful adjuncts. In the management of the difficult "functional" problem, "untreatability" often is a function of the physician's wisdom and interest in the patient, rather than of the problem itself. The key is contained perhaps in Francis Peabody's oft-quoted remark: "One of the essential qualities of the clinician is interest in humanity, for the secret in the care of the patient is caring for the patient." This care can be extremely difficult, as several of the following cases illustrate. However, the benefit to the pa-

tient and the satisfaction to the physician resulting from successful treatment are among the most rewarding in the practice of medicine.

Case 20. Funtional G. I. Distress. M. V., a 50 year old man, had been treated for an irritable bowel. He returned in 1950 with similar complaints and again underwent a thorough examination, with negative or normal findings. During the next ten years, the patient returned three to six times each year with many symptoms, including abdominal pain, belching, flatulence, constipation and diarrhea, fatigue, soreness in the eye and knees, bitter taste and coated tongue, aching in the perineum and in the region of the xiphoid process, rectal soreness and pain in the hips. The alleged presence of blood in the bowel movements led to more than 100 examinations of the feces. The alleged presence of blood in the sputum culminated in 15 chest x-rays. Other procedures included 15 roentgen studies of the digestive tract, approximately 25 physical examinations, 10 proctosigmoidoscopies, countless analyses of the blood and urine, 20 or more consultations with physicians in other areas of medicine, including chest, urology, dermatology, and orthopedics. In 1951 a psychiatric evaluation of the patient included the following: ". . . a passive, inhibited male, with many points of feminine identification. His hypochondriacal expressions are at once expressions of his primary concern with himself and defenses against object relationships (which are threatening because of their homosexual character. . .) . . . Psychotherapy could be of little value and is not indicated in the present circumstances."

During the past decade the patient has maintained an acceptable facade of useful activity. In addition to regular employment, he has been active in the civic affairs of his community. The many visits to the physician and the numerous studies apparently have provided him with some support, though the need for repeated reassurance indicates that the patient has developed little or no understanding of the nature of his difficulty. He has been untreatable in the sense that his basic emotional difficulty and the associated symptoms have not been eliminated. He may be regarded as relatively treatable in that, with support and reassurance, he has been able to function adequately.

Case 21. Obsessional Neurosis, Fear of Cancer — Value of Supportive Care. F. K., a 50 year old housewife, had had a long and consuming fear of disease, especially cancer. Many x-rays and laboratory studies, countless discussions with doctors and vast amounts of medication had failed to relieve her concern. She was first seen at the University of Chicago in August 1955. Careful examination failed to disclose evidence of disease, and the patient was treated with sedatives, antispasmodics and attempts at reassurance. In 1956 symptoms included increased anxiety and postural vertigo, and in 1957 sciatic nerve pain and an episode of viral pneumonitis. In 1958 hospitalizations were required three times for uncontrollable panic states. A fourth hospitalization disclosed the presence of cholelithiasis (asymptomatic); and a fifth hospitalization in 1958 was for acute arthritis of the right temporomandibular joint. In addition to the usual digestive complaints, other symptoms were fatigue, headache, muscle spasm, cough, and compulsions to suicide. The patient stated, "I've died a hundred times." Laboratory and roentgen studies were repeated periodically; other normal studies included gastrointestinal exfoliative cytology and examination of the bone marrow. Her physician spent countless hours with her during the three years, 1955 to 1958, explaining, clarifying, reassuring, avoiding criticism, and always expressing hope. Gradually, this seemingly untreatable patient began to respond. The reactions of acute anxiety and panic diminished, and many symptoms subsided but did not disappear entirely. During 1959 the patient improved further, though she remained vulnerable to fear of cancer; and she continued to require sedatives, analgesics, vitamins, and other medicines. In March 1960 she complained of a cough and abdominal pain; but physical examination was normal, and she readily accepted the reassurance of her physician. She appeared to be in better health than at any time in the preceding five years.

Comments: Fear of cancer assumed overwhelming proportions in this case. This "untreatable" patient has responded, at least partially, because she was fortunately under the care of an understanding physician skilled in the management of the emotionally disturbed patient.

Case 22. "Untreatable" Psychiatric Problem and Ulcerative Colitis — Response to Supportive Care, Steroids. K. M., a 30 year

old salesman, had developed ulcerative colitis in 1941 after a bacillary dysentery. Serious emotional problems, including overwhelming fears, sudden panic states and inordinate concern with his heart, became apparent. Many doctors, prescribing numerous drugs and other measures, were ineffective. Prolonged residence at two psychiatric institutions failed to induce significant improvement. The patient was described as very ill psychiatrically: "schizophrenic" and with a "fixation at the anal-sadistic stage of his psychosexual development" . . . "he would be very difficult to treat psychiatrically . . ."

The ulcerative colitis remained active and in 1950 the patient was referred to the University of Chicago. X-rays demonstrated involvement of the entire colon, rectum, and terminal ileum. There was partial response to a bland diet, sedatives, and sulfonamides. In 1951 ACTH dramatically controlled the manifestations of the colitis, but symptoms returned when corticotropin was discontinued. Between 1951 and 1955 the patient experienced recurrences, but less severe than previous ones. In 1955 hydrocortisone orally induced striking improvement. The response was maintained, though the daily dosage of hydrocortisone was reduced to 40 mg. and, subsequently, to between 20 and 40 mg.

The patient remains well on a program including small doses of hydrocortisone, sedatives, and periodic visits. He has gained approximately 35 pounds. Mild recurrences of symptoms have responded promptly to rest and medication. He has married and now has one son. During the recent illness of his wife, the patient manifested hitherto unsuspected strength.

Comments: In all probability, this patient's underlying emotional difficulties have not been eliminated. Yet he was not an untreatable, as had been predicted. Very often the sustained control of physical symptoms, as in this case, permits restoration of sufficient emotional stability for a satisfactory life.

Case 23. Severe Hypochondriasis — Response to Prolonged Correspondence. H. S. T., a 69 year old woman, had experienced gas, abdominal cramps, and fatigue since 1905 when she was discovered to have a small eventration of the diaphragm. She managed satisfactorily until 1934. Her severe exhaustion was attributed to the demanding responsibilities of housework, raising a daughter, singing, and working in her husband's business. Her husband's heart attack in 1938 greatly increased her responsibilities. The patient devoted much of her time to his care and to the business. His death in 1949 resulted in great exhaustion, increased belching, flatulence, constipation, and a weight loss of 40 pounds. She was given many drugs including hydrochloric acid, activated charcoal, laxatives, hormones, egg white; one physician recommended complete bed rest for one year. A subtotal thyroidectomy was performed in 1953. Increased symptoms, especially belching and progressive inability to walk, led the patient to seek medical care at the University of Chicago.

Except for obesity, the physical examination was normal. X-rays demonstrated mild eventration of the left diaphragm and a small herniation of the stomach. Many other studies were normal. Consultations with the dermatology, otolaryngology, neurology, and cardiovascular services indicated no abnormality in these areas. The patient was evaluated as having conversion hysteria with pronounced hypochondriasis involving the digestive tract. She was encouraged to increase her activity, but she resisted all persuasive and determined efforts. After approximately two months, she left the hospital, dissatisfied and unhappy. She seemed preoccupied with the minutiae of life and talked unceasingly of symptoms, diet, etc. In several long discussions attempts were made to explain the physiologic nature of her symptoms. In retrospect, she probably learned much from these visits.

She has never returned for further care, but has maintained a continuous correspondence with one of the staff physicians. These letters dealt with the continued use of medication for flatulence, modifications of diet, regulation of normal bowel activity without laxatives, and with the patient's activities in general. In the succeeding seven years she has improved greatly. Bowel function is much more normal, and the belching and flatulence have diminished. The patient has continued to operate her husband's business, and she has maintained an active life.

Case 24. Severe Psychoneurosis Incapacitating Hypochondriasis — Unremitting Abdominal Pain — Spectacular, Unsuccessful Operations. L. O., a 57 year old housewife, had first experienced right upper abdominal pain

in 1919 at the age of 16. In 1929 cholelithiasis was demonstrated by x-ray. In 1931, after episodes of pain presumed to be biliary colic, a cholecystectomy was performed. Within three years (1934) the patient experienced recurrent episodes of right upper quadrant pain, worse after eating of fatty and fried foods. In 1942 she was operated upon for the relief of partial intestinal obstruction attributed to adhesions. Abdominal distress returned within three months. In 1947 the pain was ascribed to pylorospasm and possible pancreatitis. In 1949 a third operation disclosed adhesions, but no evidence of pancreatitis. The abdominal pain once more recurred within three months. Later in 1950 a subtotal gastrectomy and gastroenterostomy were performed, presumably to decrease acid stimulation of the pancreas and the possibility of pancreatitis. Severe dumping symptoms ensued, and the patient lost considerable weight. In 1951 a fifth operation was undertaken to remove scarring of the gastroenterostomy stoma. A biopsy of the pancreas was interpreted as demonstrating pancreatitis. Abdominal pain was not relieved and multiple splanchnic nerve blocks were ineffective. Many drugs were prescribed without avail; opiates provided temporary relief.

In March 1952 the patient first sought medical attention at the University of Chicago. Many laboratory and roentgen studies and numerous consultations failed to demonstrate any abnormality, apart from those of the previous operations. Diagnoses of hypochondriasis, irritable digestive tract, and glaucoma were made. Usual medical measures were ineffective; the administration of ACTH failed to stimulate the patient's appetite or to induce a sense of well-being. The abdominal pain continued. Psychiatric consultation confirmed the diagnosis of severe psychoneurosis with hypochondriasis. However, the patient refused formal psychotherapy.

In June 1955 levo-dromoran and sterile hypodermic injections seemed to provide relief of the abdominal pain. However, in November the pain returned, and the surgeon caring for the "untreatable" patient performed a transthoracic vagotomy and left splanchnicectomy, removing the left paravertebral sympathetic chain; partial and temporary improvement followed. In January 1957 severe chest pain developed; neurogical examination was normal. Intercostal nerve blocks were unsuccessful. In April 1957 the surgeon sectioned the sixth and seventh intercostal nerves but intercostal neuralgia returned in August; nerve blocks, at times with saline, were helpful temporarily. The patient continued in this manner until April 1959, when the twelfth University of Chicago hospitalization was required to investigate an iron-deficiency anemia. Gastrointestinal studies were normal, and the patient was treated with an ulcertype program. The pain in the chest in the region of the thoracotomy continued. A similar study in September 1959 was also normal. In December 1959 the patient was hospitalized for the extraction of a cataract. The persistent abdominal pain renewed discussion of psychotherapy; but again the patient refused. She has been hospitalized recently for the fifteenth time in the past eight years at the University of Chicago for surgery upon the eye. The abdominal pain has been supplemented by the pain of rheumatoid arthritis.

Comment: The underlying problem of this severely disturbed, hypochondriacal and hysterical woman obviously has been psychogenic rather than organic. In retrospect, pancreatitis probably had never existed, and the many major surgical procedures were doomed to failure. The patient, a deeply religious woman, appeared to adopt the masochistic role of a martyr, frequently citing passages from the Bible by Apostles who had suffered. Intelligent psychotherapy might have been helpful and probably would have spared the patient many operations and considerable pain. Her refusal to accept psychotherapy might have justified denial of further care. Yet, the patient was sick and in need of a doctor. This need did not, of course, include multiple surgery; and it may be argued that the many operations intensified rather than eased the problem. Though neither the attending physicians nor the surgeon today would justify the operative procedures, the clinical situations were not always easy to evaluate. The intense medical and surgical attention and the countless hours of discussion, seemingly in vain, probably were helpful to the patient, supporting her dependent hysterical needs, thereby preventing complete psychotic deterioration. Despite the many hospitalizations, the patient, with the aid of a devoted husband, has maintained her family and home, and, to this degree, a partially useful role in life.

Case 25. Incapacitating, Life-Long Psychoneurosis — Failure of Drugs, Doctors — Partial Response to Reassuring Support. E. P., a 58 year old housewife, had a life-long history of illness, including scarlet fever, typhoid fever, appendectomy, twisted ovarain cyst, partial hysterectomy, "blackouts", and apparent convulsive episodes. In 1928, about nine months after her marriage, she developed increasing nervousness, fatigue, and constipation. She maintained a variable course until 1940, when she experienced a nervous breakdown during her father's illness. In 1941 the intestines allegedly had "dropped," and they were "suspended" surgically, without benefit. Between 1941 and 1951, the patient experienced many symptoms, including anorexia, cramps, flatulence, diarrhea and constipation. In 1951 the symptoms increased; her weight dropped from 130 to 85 pounds, and fluids parenterally were given.

In 1954 she was seen at the University of Chicago for the first time, complaining of anorexia, weakness, constipation, and many other symptoms. Clinical observation and many studies led to diagnoses of chronic anxiety with depression and an irritable digestive tract. The patient had taken vast amounts of drugs, and she strongly resisted efforts to reduce the number. She was bedridden and unwilling to increase her activity. The next few years were characterized by repeated hospitalizations for the same problems, supplemented by dizzy spells, a skin rash, and an hysterical episode. There was no evidence of neurologic disease. In 1956 the patient complained of severe pain in the left chest. The tendency initially was to disregard this complaint; but x-rays disclosed fractures of several ribs. The pain, allegedly, was intense, and intercostal nerve blocks were made at many visits. The patient remained bedridden and maintained her delusion that, unless she took many pills, she would become even more seriously ill. These medications included sedatives, antispasmodics, antihistaminics, vitamins orally and by injection, Dilantin®, laxatives, cathartics, anti-laxative drugs, calcium, estrogens, ointments, suppositories, and salicylates, and other unidentified and unrecorded medications. The patient was evaluated psychiatrically as a severely incapacitated psychoneurotic with a passive-aggressive personality greatly in need of psychotherapy.

According to the psychiatrist, she had been forced into a hostile and dependent relationship with her continuously sick mother during the mother's terminal illness; and now she manifested the same hostile relationship with members of her own family. The time spent in reassuring the patient and in endeavoring to provide her with insight cannot be measured; the output of physician time and energy was enormous; but to no avail. The patient clung to her complaints and her bed clothes.

At this time (1957) the attending physician concluded that he had not proved useful to this disturbed patient and was not likely to be helpful to her in the future. Another sympathetic but firm physician now undertook the patient's care. This change was followed by an unexpected improvement. The patient's appetite increased and she gained weight. She became more active and her digestive symptoms decreased. In 1960, though retaining numerous symptoms and medications, she appears to be functioning more satisfactorily.

Comments: Like the preceding case, this patient presents a virtually unapproachable emotional problem. A significant disturbing factor had been her husband's alcoholism and his apparent rejection of the patient. An important supporting factor has been the patient's only daughter upon whom she has become quite dependent. The physician who sought to re-educate the patient and to decrease the fantastic list of drugs was ineffective, because this approach threatened the patient's well-organized system of dependency through illness. The physician who provided sympathetic care and who did not interfere with her medication was more successful because he did not threaten the dependency status. To the first physician the patient was untreatable, but to the second physician she was relatively treatable. Formal psychotherapy, if this had been acceptable to the patient, might have been more effective.

Concluding Remarks

The ultimate goal of medicine presumably is the relief of suffering and the cure and prevention of disease. This idealistic objective is far from complete accomplishment, of course, and probably will never be achieved. However, remarkable progress has been made, as these cases illustrate. Today many effective approaches, med-

ical and surgical, are available for treatment of the "untreatable," and the numbers of such cases are diminishing. The physician, consequently, must endeavor to remain thoroughly informed on the newer diagnostic and therapeutic advances, and on the newer research developments so that he may be better able to deal with, control, and perhaps cure previously unapproachable problems.

Yet the successful therapeutic results described do not imply that all critically ill, untreatable patients can be dealt with satisfactorily at the present time. Many extremely difficult and insoluble problems yet remain: organic disorders such as relentless cardiac failure, advanced renal insufficiency and overwhelming leukemia or cancer; and psychogenic disturbances such as schizophrenia, severe hypochondriacal and hysterical states.

It is in the skilled and devoted care of the hopelessly untreatable that the doctor rises to his greatest heights as a true physician, as a "fellow human being and as a friend"; offering thoughtful attention, cautious encouragement, and sympathy to the patient, understanding and solace to the family; and facilitating the quiet departure of the fatally ill with proper spiritual consideration and with dignity. We often do not appreciate fully how communicative we are as physicians in our unguarded facial expressions, in the subtleties of our attitudes, the nuances of our remarks, and, even more, by thoughtless comments or failure to express ourselves adequately. L. J. Henderson's sage advice was "In the practice of medicine do as little harm with words as possible." To this I would add: "Provide as much hope and reassurance with words as is reasonably possible." We can do much for our patients by this simple but vital approach.

The achievements of many great but physically handicapped people also remind us of other important influences, in addition to scientific accomplishments, in the successful management of seemingly hopeless problems: factors such as the faith and determination of the patient, the priceless attention of the devoted nurse; and the true interest, wisdom, and skill of the physician who seeks to accomplish everything beneficial for the patient in the Hippocratic tradition ". . . I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients. . ."

At times, medication alone is not enough; occasionally, hope and determined effort triumph when all seems lost; the art of medicine often is as necessary as the science, as all of you appreciate and practice so well. This paper, in effect, reaffirms that, extraordinary medical advances notwithstanding, the practicing physician, specialist and practitioner alike, remains the indispensable and decisive influence in the care of the sick.

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REFERENCES

Adams, F.: The Genuine Works of Hippocrates. Baltimore. Williams and Wilkins Co., 1939.

Brosin, H. W.: The Doctor and His Patients. Postgrad. Med. 20:528, 1956.

Cabot, R. C., and Dicks, R. L.: The Art of Ministering to the Sick. New York, The Macmillan Company, 1936.

Hollander, M. H.: The Psychology of Medical Practice. Philadelphia, W. B. Saunders Co., 1958.

Huggins, C.: Control of Cancer of Man by Endocrinologic Methods. Cancer Research 16:825, 1956.

Kirsner, J. B., and Palmer, W. L.: The Irritable Colon. Gastroenterology 34:491, 1958.

Palmer, W. L.: Posthospitalized Patient with Cancer. J.A.M.A. 137:1583, 1948.

Ross, S. E.: The Misuse of Sympathy. Correspondence. J.A.M.A. 172:2109, 1960.

Smith, C. A.; Chapman, E. M.; Chase, P. P.; Beck, I. A., and Clark, S. L.: Help for the Hopeless. Rhode Island M. J. 39:491, 1956.

Van Prohaska, J.; Nelsen, T. S., and Evans, S. O.: Radical Surgery in Advanced Cancer of Intra-Abdominal Organs. Arch. Surg. 73:671, 1956.

Wildermuth, O.; Parker, D.; Archambeau, J. O., and Chahbazian, C.: Management of Diffuse Metastasis from Carcinoma of the Prostate. J.A.M.A. 172:1607, 1960.

Vascular Complications of Pregnancy

Eugene A. Osius, M.D.,* *Detroit*

Almost any type of vascular complication can occur during pregnancy or postpartum. I shall discuss some of the more frequent of these complications.

Hemorrhage in obstetrics[1]

In obstetrics, hemorrhage is not an infrequent complication. It may arise from mechanical causes, such as uterine atony, placenta previa or abruptio, severe lacerations of the cervix, ruptured varices of the vagina, or lacerations of the perineum. Other causes are blood dyscrasias, such as the anemias, purpuras, severe infections, jaundice, and afibroginenemia. The latter complication, failure of the blood to clot, can accompany abruptio placentae, transfusion reactions, or even ordinary massive hemorrhage. Fibrinogen is specific for this condition, but whole fresh blood given by direct transfusion may be substituted when necessary.

Today we take transfusions for granted because blood is readily available, and it can be administered easily. We have become a bit complacent, even careless, in using them. Often a little planning and careful consideration of situations could make them unnecessary. Transfusions are not without danger in themselves and may lead to complications more serious than the condition being treated. Reactions with lower nephron syndrome and damage have been followed by death or by serious kidney impairment during the subsequent years. The obvious treatment of a reaction, even a doubtful one, is immediate cessation of transfusion, complete rechecking of typing and identification, and—if urinary supression should ensue—reduction of fluids to approximately 1,000 cc. of 5 per cent glucose in water per 24 hours intravenously, plus an amount that will compensate for losses of fluid and any urine voided. The syndrome may continue from 24 hours to 10 or 15 days; a decreasing secretion of urine during the first 48 to 72 hours usually is a bad omen. An artificial kidney sometimes carries the patient through a critical period, but it is a complicated machine that in itself involves certain hazards.

Coarctation of the aorta[2-13]

In the past 25 years rapid advances in knowledge of cardiovascular anomalies and diseases and their therapy has imposed new demands upon the obstetrician. It is mandatory that obstetricians have a working knowledge of these conditions, and knowledge of what may be benefited by therapy. Coarctation of the aorta as such is not a common finding—approximately 0.12 per cent at autopsy in females—but many feel that the disorder is not always recognized. Despite the low incidence published, pregnancy with coarctation is not rare. One of its outstanding features is hypertension, and in obstetrical practice every patient with hypertension should have blood pressure and pulses of the lower extremities checked for any discrepancy between them and the upper extremities. Systolic murmurs often are heard through the back, and in one-third there is a diastolic murmur. Occasionally, x-ray films show notching of the ribs. The symptoms often are confused with toxemia, cardiac distress, or the hypertension of pregnancy.

Cause of death usually is rupture of the aorta or of the cerebral vessels, as pregnancy has a deleterious effect on coarctation. Treatment in the first trimester is resection of the coarctation as shown by Hufnagel and others. Conservatism is in order if the patient is seen later, and pregnancy is terminated if the heart or aorta dilate or if cerebral symptoms develop and hypertension increases. Schnitker and Bayer reviewed 49 cases of spontaneous dissection of the aorta in women and discovered that 24 (50 per cent) occurred late in pregnancy.[5] The

*From the Department of Surgery, Harper Hospital, Detroit.

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theory has been advanced that these developed due to loss of elastic tissue bulk plus increased blood volume and pressure changes and so-called cystic degeneration of the media, known as Erdheim's medionecrosis. Such elastic tissue changes occur in varying degree in all pregnant women and are evidenced by relaxation of certain joint ligaments, varices, or pes planus. In a series of 70 dissecting aneurysms in women reported by Mandel, Evans and Walford, 51 per cent were associated with pregnancy and showed medionecrosis.[3]

Splenic artery aneurysms[14-16]

Cosgrove, Watts, and Kaump reviewed 107 cases of splenic artery aneurysms reported in the literature and added three cases; of 60 cases in females, one-fourth were associated with pregnancy, chiefly at or near term.[16] There are few premonitory signs of rupture. The onset is devastating, and the patient usually is moribund before aid can be given. Diagnoses have been made in a few cases when the rupture evidently was not complete; when leaking had occurred as evidenced by earlier upper abdominal distress, tenderness, rigidity of the abdomen, mild signs of shock, and anemia; and when, courageously, laparotomy was performed. A few have survived. X-ray plate of the abdomen sometimes reveals a calcified lesion in the region of the splenic artery. These calcified plaques may provide a good radiologist with a clue pointing to splenic aneurysm.

Arteriovenous fistula[20]

Gottesman, Wilchius, and Aronoff in 1957 reported an unusual case of arteriovenous fistula of the ovarian artery and vein. The patient had been operated on in 1946 for ectopic pregnancy. About nine years later, three days postpartum, she had increasing pain in the right lower quadrant with vaginal passage of blood clots. She was in shock. The uterus was at the umbilical level; a strong thrill was felt to the left of the uterus; and a loud machinery murmur was heard. The uterus involuted normally, but the bruit and thrill persisted. Surgery disclosed an aneurysm of the ovarian artery and uterine vein.[17] This situation occurs occasionally in a pedicle after amputation where an artery and vein have been tied with the same ligature.

Ovarian varices and hemorrhage[18]

Hemorrhage from rupture of broad ligament varices during pregnancy may be rare, but the mortality warrants its consideration. In 1950 Hodgkinson and Christensen in a complete review of the literature, found 75 cases with a 50 per cent mortality.[19] Multiparas suffered more than primiparas, and 44 of 75 occurred during or just after delivery. The onset often is sudden and at a time when other factors can cloud the picture. Shocklike onset with zero blood pressure, cold extremities, and signs of peritoneal irritation betoken a serious catastrophe. Onset and course may be so rapid as to preclude surgery. Diagnostic abdominal tap with a needle may be of some help and should be done. Occasionally, complete hemorrhage does not occur. Clot formation seals the wound in the vein temporarily, but minimal disturbance such as a pelvic examination or undue motion can easily dislodge the clot and cause recurrence of bleeding. It is thought that the venous pressure, which is 100 to 200 mm. of water higher than in the axillary veins, plus the thinness of the veins, increased blood volume and the strain of labor, lead to rupture of the varices.

Venous disorders

Acute massive venous occlusion[21,22], or phlegmasia cerulea dolens, although rare, has been reported as occurring during pregnancy. We have been particularly interested in this entity for some years but have not encountered it in pregnancy. The somewhat terrifying condition produces appreciable mortality as well as morbidity. It is characterized by sudden onset of severe pain and swelling of a lower extremity in a few hours. The limb appears about to burst, becomes cyanotic and cold with marbleized blotching or mottling. Arterial pulses frequently are absent, leading to the mistaken diagnosis of arterial embolism. This is due to intense vasospasm and complete cessation of blood flow because of sudden venous occlusion. After administration of morphine and antispasmodics the pulses will return in time, making the true diagnosis more evident.

Areas of gangrene not infrequently develop. Digits and limbs have been lost even when the arterial system was patent, although gangrene is more likely to be superficial than deep.

Hence a conservative attittude toward this complication should be adopted. J. Ross Veal has advocated high elevation of the extremity and motion to aid venous flow. Others have used anticoagulants and antispasmodics freely, but we have felt that venous thrombectomy is indicated, just as embolectomy is indicated in arterial occlusion. A possible cause is an unrecognized phlebothrombosis in the leg suddenly becoming dislodged and impacting itself in the iliac vein, and with lightning suddenness completely occluding venous return from the lower extremity. Thrombectomy in our cases has been beneficial.

Antenatal embolism[23]

Relatively few cases of antenatal embolism are reported, and its incidence possibly is lower than in the postnatal period. A review of the literature and postmortem reports usually shows the lesions to be of phlebitic or venous thrombotic origin. Antepartum thrombosis is rare but important. A recent survey of vascular surgeons revealed that only about one-half had ever seen phlebitis during pregnancy, and few had seen more than one or two cases. Ullery reported 38 cases of antepartum thrombosis with emboli and no deaths under anticoagulant therapy; in 97 patients who did not receive any treatment, 18 emboli and 15 deaths occurred.[24]

Phlebitis[25-32]

Our experience has led us to divide so-called phlebitis into two classifications: superficial and deep. The superficial are those occurring in a saphenous vein, either greater or lesser. Deep phlebitis occurs in the tibials, peroneals, popliteals, femorals, and iliacs.

It has been our custom to treat superficial saphenous phlebitis as a potentially threatening lesion. Despite many statements to the contrary, it can be associated with pulmonary embolism. A thrombus in a superficial vein is not potentially different from one in a deeper vein; nor is its susceptibility to being dislodged any less. We treat it as an emergency and ligate the saphenous vein either at the femoral or the popliteal junction, depending upon the vein involved. The vein is exposed under local anesthesia and in each instance is opened and examined for a thrombus. On numerous occasions after palpation of the vein, we have ventured the opinion that the vein was empty but upon opening it have found a soft, friable, easily dislodged thrombus projection into the femoral blood current. It requires only one such case to prove that superficial phlebitis is not without danger. The saphenous vein is ligated and divided at the femoral junction, the extremity is supported by means of an elastic bandage, and the patient is discharged to her home. Activity and walking, which are advisable to keep the deeper vessels functioning well and the blood flow active, are achieved better at home than in a hospital.

Many writers have classified deep phlebitis into three general classifications: phlebothrombosis, thrombophlebitis, and septic thrombophlebitis. With this we have no quarrel, although we feel that sometimes one merges into the other and there are varying stages of each. The important thing is to diagnose the entity and take steps accordingly. Since signs and symptoms of phlebothrombosis often are meager, the diagnosis must be made from relatively few of them. The clinician should be alerted by a patient's offhand remark about a "little pain in my side", "a little soreness in the leg", or " a charley horse." Careful examination should be undertaken immediately. Both legs should be uncovered to the anterior superior spine of the ilium and inspected. Small differences in the size of the extremities and dilatation of some of the so-called sentinel veins in the upper third of the leg (just below the knee) are a tip-off to the diagnosis. Sometimes a slight puffiness of the extremity is noted. The next step is palpation of the arterial pulses—the dorsalis pedis, the posterior tibial, popliteal, and femoral. Then—with the knee extended—gentle dorsiflexion of the foot is instituted; 50 to 60 per cent of patients note some tenderness in the posterior calf. This is Homan's sign. However, we have used a more accurate method—flexing the knee with the foot resting on the bed and palpating the calf on the midposterior area, with the thumb over the tibia, examining the posterior calf inch by inch.

Tenderness in a very small area is sufficient evidence for diagnosis. Tenderness also may be found in the lower third of the thigh just above the condyles at the point where the femoral and popliteal veins are approachable. The leg and thigh may show more warmth or coolness compared to the opposite side and look somewhat

whiter or at times even slightly cyanotic. Occasionally there is a simultaneous slight rise in temperature, pulse, and respiration. One or two of these signs are sufficient for diagnosis. Sometimes a small embolus is the earliest sign. Treatment is either ligation of the superficial femoral vein, just distal to the profunda, or anticoagulant therapy.

The term thrombophlebitis generally is reserved for that type of phlebitis associated with infection and temperature ranging to 103 or 104 F., increased pulse rate, chills, malaise, marked leg tenderness, and somewhat more swelling of the extremity than in early phlebothrombosis. Sometimes there is a history of respiratory or postpartum infection, operative procedure, or the like. Treatment of the two types does not differ remarkably, although we are much less prone to ligate this type. We feel antibiotics are indicated, whereas in phlebothrombosis we see no indication for their use. Paravertebral block for relief of pain has been advocated, and to this we would agree, with some modification. Bed rest and elevation of the extremity are ordered in both instances, and careful observation for complications is maintained. We do not favor flexion of the knees. Anticoagulants are used, and symptoms treated as they arise.

Septic thrombophlebitis is a serious disease not encountered frequently. Apparently it is more prevalent in the South, as relatively large series of cases are reported from those areas. This may be due to the type of patient, the prevalence of predelivery meddling, illegal abortions, poor hygiene, or low mental status. The disorder is a life hazard and consists of repeated detachment of small septic emboli from a focus, either in the extremities or the pelvis, usually the latter. These patients are critically ill, have high temperatures and chills, and are septic and toxic. If the process is localized in the lower extremity, ligation of the femoral and, in some cases, the common iliac vein is indicated. Generally speaking, however, ligation of the inferior vena cava is justified. This procedure is lifesaving and is done for that sole purpose. Whatever sequelas ensue must be balanced against this fact. We do not believe that ligation of the inferior vena cava involves small risk of morbidity. Our experience has been contrary, and we feel that careful consideration should precede a decision to employ the procedure. Anticoagulants and antibiotics are used.

Any phlebitis is an acute emergency second only to hemorrhage, and immediate treatment is indicated. Some clinics, such as the one at Duke University, have developed teams consisting of an obstetrician, a surgeon, and occasionally an internist. This group reviews all suspected cases of phlebitis, thrombosis, or embolism. Six years of their work has been reported.[5]

Therapy for phlebitis

After diagnosis is made, we institute the following regimen: 50 mg. of heparin are given intravenously every four hours around the clock, and 300 mg. of Dicumarol® are given by mouth. A daily as well as an immediate prothrombin time is taken. The second day 200 to 250 mg. of Dicumarol are given and heparin is continued. The third day we give 100 mg. of Dicumarol. If the prothrombin time has dropped to about three times normal, or approximately 30 to 36 seconds versus a normal control of 12 seconds, heparin is discontinued and Dicumarol continued as necessary to maintain this level. Maintenance requires 25 to 75 mg. per day and is continued for 12 to 14 days, as indicated by regression of symptoms. Many aches and pains in the phlebitic leg will disappear within hours after the administration of heparin. We feel this product is necessary for immediate results in this emergency and that some patients can be treated with heparin only when liver or kidney damage or other conditions contraindicate Dicumarol. Insertion of a small polyethylene tube attached to a cartridge-like container, with a rubber-covered connection, can be used to eliminate the need for repeated venipuncture.

We have not had great difficulty in carrying out this regimen, provided the house coverage is adequate. The postpartum patient is watched carefully; if excessive bleeding occurs, treatment is stopped and the anticoagulant neutralized with protamine sulfate for heparin and Mephyton® for Dicumarol. We have had little difficulty with bleeding.

Some have expressed concern and questioned whether anticoagulant therapy given antepartum for phlebitis affects the child in utero adversely. Our experience and the literature indicate that anticoagulants are well tolerated, and to date serious damage has not been reported. Several writers have reported carry-over of the anticoagulant and that some infants tended to bleed post-

partum, but this apparently is not prevalent and occurred only when treatment continued into the delivery period. Careful checking of prothrombin time and supervision to guard against overdosage is requisite, and one person should be responsible for ordering the drug. After recovery, the patient is not allowed out of bed until a well fitting elastic bandage or an elastic stocking has been applied. If ambulation is allowed without support, edema almost invariably will develop; it is very difficult to get under control and actual damage is done to the leg. Application of a good support, with strict injunction that it is to be worn at all times when not in bed is necessary. We believe this is a practical and important point. Elevation of the extremity to well above the level of the body two or three times daily for 15 to 20 minutes is helpful. Patients are warned against trauma and injury to the extremity, not to stay in the same standing or sitting position too long and not to take automobile trips without getting out at least every hour and moving around actively. Our firm conviction is that many sequelae of thrombophlebitis are the result of carelessness rather than of the disease itself.

Varicose veins[33-42]

One of the most common complications of pregnancy is varicose veins. They make the immediate pregnancy troublesome and frequently remain to cause difficulty in the future. In spite of excellent and extensive prenatal care, 75 to 80 per cent of varices develop during pregnancy. Good prenatal care undoubtedly has done much to minimize this complication and to assist patients in the care of varices. The increased activity of the modern woman in work and sports, short skirts, shorts, nylon stockings, and scanty swimming suits have all helped make patients and physicians acutely aware of varicosities. Treatment is justified when they are accompanied by distress, aching, tiredness of the legs, nocturnal claudication, pruritus, fatigue, self-consciousness, irritability, and other symptoms. Varices are forerunners of edema, eczema, thickening of the tissues, pigmentation, varicose ulcers, induration, and phlebitis, among other conditions. Fungal infections and pes planus often coexist.

Familial tendency toward varices is definite. I am certain an endocrine factor must be involved because some women show a certain degree of dilatation as early as the fourth to sixth week of pregnancy. This re-emphasizes the loss of elastic tissue bulk in other areas. With increased blood volume and later pressure on the pelvic vessels, it is remarkable that not all patients have varices. Prompt subsidence of the veins occurs postpartum in many instances.

In the last 25 to 30 years a considered, rational, and logical approach to the treatment of varicosities has been developed. There are many pros and cons regarding the best antepartum treatment. We believe that conscientious conservative therapy suffices in most cases, and that risk of radical treatment during pregnancy is not justified, small though it may be. We recommend a well fitting support from as early as possible in the pregnancy to some time after the patient has been delivered. Vulval varices occasionally have given some difficulty, but use of a pad and an athletic type of support usually has been sufficient to give relief. Few vulval varices have required operation. We believe the following facts support our stand.

1. Pregnancy is not a permanent condition except in most unusual families.

2. Many varicosities disappear spontaneously or are much improved postpartum.

3. During pregnancy, with blood volume increased and greater pressure in the veins, any operative procedure is certain to be attended with greater bleeding.

4. More varices can develop later in pregnancy, even though some have been removed.

5. Our feeling is that high ligation and stripping of the varicosity is far superior to ligation and injection. It is more extensive, requires general anesthesia, and may take from two to five hours. We do not feel it is wise to subject a pregnant woman, and her child, to such extensive procedures unless there is an emergency. In over 99 per cent of pregnant women the varix is not an emergency. When most writers speak about operation during pregnancy, they are referring to ligation and injections. I agree that these measures are less formidable, but they also are less efficient. We set an arbitrary limit of six to eight months postpartum for the treatment of varicosities because:

1. The mother's tissues have returned fairly close to normal. She has begun convalescent recovery, and many of the varicose veins have disappeared or regressed.

2. The child is at a better age to be cared for by some one other than the mother. We have in some instances advised patients who are young and in whom varices are not too extensive to delay surgery until the believe they have begotten most of their family. Fifty per cent of patients who have had veins stripped and again become pregnant may have recurrence of some varices.

Our general procedure is to have the patient admitted to the hospital the afternoon before operation. The next morning, with the patient standing, all visible, dilated veins are marked with a 3 per cent aqeous solution of gentian violet. This permits delineation of the veins during surgery when the patient is recumbent and the veins are collapsed. The extremity is prepared by painting with iodine and removing the excess with alcohol. This fixes the gentian violet stain so that a vein will not be overlooked. Careful ligation of the saphenous vein at the saphenofemoral junction is done, being sure to ligate all branches, and then—with an intraluminal stripper or by dissection with hemostats—the saphenous vein and if necessary the lesser saphenous are removed, generally from below upward. We do not hesitate to make as many incisions as are necessary to obtain thorough and complete removal. Wounds are closed with silk except those of the groin where subcuticular wire is used. We have found this produces less reaction in an area where perspiration and infection may induce cellulitis. Elastic bandages are applied from the base of the toes well up onto the thigh. The following day the patient is ambulatory.

The upper elastic bandage on the thigh is removed in 24 hours to facilitate walking. The lower bandage from toe to knee is retained. The patient is discharged on the fourth to fifth day and told to report to the office on the seventh day for removal of sutures. The elastic bandage or stocking is worn for several weeks or until all swelling has disappeared. Subsequent follow-ups are made at stated intervals and finally, yearly. Any small varix remaining may be injected in the future if necessary. We have used these procedures successfully for some 31 years. Our indications and contraindications for operation are logical and have given satisfactory results.

Cerebral vascular lesions[43]

When these lesions are associated with pregnancy, the mortality reported is 40 per cent. Their chief importance is the fact that often they are labeled erroneously as toxemias of pregnancy, because the patient has hypertension, convulsions, coma, and albuminuria. Most writers describe cerebral vascular aneurysms as congenital and with lack of elastic and muscle fibers. As stated, with its effect on elastic tissue, pregnancy makes these areas vulnerable, especially in the third trimester. The onset of headache, emesis, convulsions, coma, loss of consciousness, signs of meningeal irritation and neck rigidity, and occasionally, signs of paralysis, should lead to consideration not only of toxemia but also of rupture of a cerebral aneurysm.

Pedowitz and Perell make a plea for more neurological consultations and lumbar punctures under circumstances in which the presence of blood will help diagnosis. They advocate bed rest, sedation, support, and an arteriogram after eight days. The surgical approach is either intracranial or, more often, internal or common carotid ligation. In their collected series 37 per cent died with the first attack, and 68 per cent of the survivors died with the second attack. They conclude that operation at the right time is indicated. They also report that of 11 patients treated surgically, six were operated on during pregnancy without a maternal or fetal death.[9] This is surprising but the series is small. Our neurosurgeons consistently have followed conservative policy in the management of intracerebral vascular accidents of both types. Intracranial hemorrhage secondary to hypertension and toxemia also is a source of similar clinical findings and has led many obstetricians to forego the use of oxytocic or vasopressor agents in normal pregnancies. This whole field needs further study, evaluation, and clarification.

Summary

Some of the vascular complications of pregnancy have been reviewed and discussed. Suggestions are made for their care and treatment.

901 David Whitney Bldg.
Detroit 26, Mich.

REFERENCES

1. Collins, Jason H., and Batson, Hiram W. K.: Vascular Complications of Pregnancy, Wisconsin M. J. 53:361, 1954.
2. Rosenthal, L.: Coarctation of Aorta and Pregnancy, Brit. M. J. 1:16, 1955.
3. Mandel, W.; Evans, E. W., and Walford, R. B.: Dissecting Aortic Aneurysm during Pregnancy, New England J. Med. 251:1059, 1954.

4. Tebow, L. E.; Hufnagle, C. A., and Brown, R. B.: Surgical Correction of Coarctation of the Aorta during Pregnancy, Am. Surgeon 20:1277, 1954.
5. Schnitker, M. A., and Bayer, C. A.: Dissecting Aneurysm of Aorta in Young Individuals Particularly in Association with Pregnancy, with Report of Case, Ann. Int. Med. 20:486, 1944.
6. Benham, G. H. H.: Pregnancy and Coarctation of the Aorta, J. Obst. Gynaec. Brit. Emp. 56:606, 1949.
7. Pritchard, J. A.: Coarctation of the Aorta and Pregnancy, Obst. & Gynec. Surv. 8:775, 1953.
8. Shanahan, W. R.; Rowney, S. L., and Currens, J. H.: Coarctation of the Aorta and Pregnancy, J.A.M.A. 167: 275, 1958.
9. Pedowitz, P., and Perell, A.: Aneurysm Complicated by Pregnancy, Am. J. Obst. & Gynec. 73:720, 1957.
10. Porter, A. M.: Coarction of Aorta, Case Report, Brit. M. J. 2:1541, 1955.
11. Miettinen, Von M.; Hakkila, J. and Sipila, W.: Uber Coarctation der abdominellen Aorta sowie Bericht über einen Fall mit drei Schwangerschaften, Ztschr. Kreislaufforsch. 45:33-39, 1956.
12. Dixon, H. G., and Hartley, R.: Behaviour of the Blood Pressure in Pregnancy Associated with Coarctation of the Aorta, J. Obst. Gynaec. Brit. Emp. 62:83, 1955.
13. Platt, K. A.: Raynolds, M. W., and Neerken, A. J.: Coarctation of Aorta and Pregnancy, Rocky Mountain M. J. 53:308, 1956.
14. Poidevin, L. O. S.: Rupture of Splenic Artery Aneurysm in Pregnancy, M. J. Australia 1:922, 1955.
15. Tanner, F. N., and Miller, H. B.: Rupture of Splenic Artery Aneurysm during Pregnancy, Nebraska M. J. 40:9, 1955.
16. Cosgrove, G. E., Jr.; Watts, J. C., and Kaump, D. H.: Spontaneous Rupture of Splenic Arterial Aneurysm; Report of 3 Cases, Am. J. Clin. Path. 17:372, 1947.
17. Gottesman, L.; Wilchius, L. J., and Aronoff, N.: Arteriovenous Aneurysm of the Ovarian Artery and Vein, Ohio M. J. 53:1428, 1957.
18. Beaudry, E., Gosselin, L.: Hémorragie par rupture de varices du ligament large en cours de grossesse, Laval med. 21:149, 1956.
19. Hodgkinson, C. P., and Christensen, R. C.: Hemorrhage from Ruptured Uteroovarian Veins during Pregnancy, Am. J. Obst. Gynec. 59:1112, 1950.
20. Burwell, C. S.: The Placenta as a Modified Arteriovenous Fistula Considered in Relation to the Circulatory Adjustments to Pregnancy, Am. J. M. Sc. 195:1, 1938.
21. Osius, E. A.: Acute Massive Venous Occlusion, A.M.A. Arch. Surg. 65:19, 1952.
22. Veal, J. Ross; Dugan, T. J.; Jamison, W. L., and Bauersfeld, R. S.: Acute Massive Venous Occlusion of the Lower Extremities, Surgery 29:355, 1951.
23. Sibthorpe, E. M.: Antenatal Pulmonary Embolism; Report of 3 Cases, Brit. M. J. 2:1063, 1955.
24. Ullery, J. C.: Thromboembolic Disease Complicating Pregnancy and Puerperium, Am. J. Obst. & Gynec., 68:1243, 1954.
25. Parker, R. T.: Anlyan, William G.; Mairs, D. A., and Carter, B.: Thromboembolic Complications of Pregnancy, South. M. J. 50:1228, 1957.
26. Mansell, R.: Antepartem Dicoumarol Therapy, Am. J. Obst. & Gynec. 64:155, 1952.
27. Bach, H.: Thrombophlebitis ünd Thrombose in der Spatschwangerschaft und in Wochenbett Ihre Behaudlung mit Antikoagulantin, Zentralbl. Ynak. 29:1135, 1957.
28. Morin, P., and Chabrier, J.: Les-thrombo-phlébites de la grossesse, Gynéc. et obst. 54:400, 1955.
29. Nijenhius, W. T. P.: Effect of Dicumacyl Administration during Pregnancy on Mother and Infant, Nederl. tijdschr. geneesk. 99:2062, 1955.
30. Lloyd, T. J., Jr.: Dicoumarol in Antepartum Thrombophlebitis: A Case Report, Virginia M. Month. 84:11, 1957.
31. vanAssen, F. J. J., and Kooy, H. J.: Influence of Dicumacyl Administration during Pregnancy on Mother and Newborn, Nederl. tijdschr. geneesk. 99:107, 1955.
32. Quenneville, Guy; Barton, B.; McDevitt, E., and Wright, I. S.: The Use of Anticoagulants for Thrombophlebitis during Pregnancy, Am. J. Obst. & Gynec. 77:1135, 1959.
33. Cavanagh, M. J., and Weinberg, P. C.: The Treatment of Varicose Veins in Pregnancy, U. S. Armed Forces M. J. 5:1519, 1954.
34. Peyton, F. W., and Loop, F. A.: Saphenous Phlebectomy for Varicose Veins during Pregnancy, Am. J. Obst. & Gynec. 58:318, 1949.
35. Ritchie, Alison: Treatment of Varicose Veins during Pregnancy, Edinburgh M. J. 40:157, 1933.
36. Hamilton, H. G.; Pittam, R. F., and Higgins, R. S.: Active Therapy of Varicose Veins in Pregnancy, South. M. J. 42:608, 1949.
37. Dodd, Harold: Operation for Severe Varicose Veins during Pregnancy, Lancet 256:606, 1949.
38. Sullivan, J. M.: Varicose Veins in Pregnancy, Wisconsin M. J. 49:291, 1950.
39. Shank, P. J.: The Treatment of Varicose Veins during Pregnancy by Combined High Saphenous and Segmental Ligations Followed by Injection of Residual Varicosities, Ohio M. J. 44:477, 1948.
40. Greenstone, S. M.; Beringman, E. C., and Massell, T. B.: Management of Varicose Veins during Pregnancy, California Med. 87:365, 1957.
41. Quattlebaum, F. W., and Hodgson, J. E.: The Surgical Treatment of Varicose Veins in Pregnancy, Surg. Gynec. & Obst. 95:336, 1952.
42. Weed, J. C., and Hatch, H. B., Jr.: A Contribution to the Study of Varicose Veins in Pregnancy, Am. J. Obst. & Gynec. 77:1130, 1959.
43. Mack, H. C.; Schreiber, F. E.; Nielsen, A., and Huber, P. J.: Intracranial Hemorrhage Associated with Pregnancy, Harper Hosp. Bull. 14:249, 1956.

Phonies

There are so many claim-minded people around my area that it has become common for a person who has had a property damage auto accident to be asked by a neighbor or friend, "Aren't you even going to see a doctor?" Note the neighbor does not ask, "Were you hurt?" It is taken for granted that all anyone has to do to get paid for an injury claim is to see a doctor.

By A Veteran Insurance Adjuster. I'm Fed Up with Phony Claims. J. of Am. Insurance. April 1960.

A whale of a cure

Several persons suffering from rheumatism have arrived at Eden en route for the Kiah whaling station, whither they are going for the purpose of the whale-bath cure. The treatment consists in the patient, divested of clothing, repeatedly remaining for a long time in the interior of the dead whale. Some remarkable cures are said to have been effected by this treatment.

The Sydney Morning Herald, October 18, 1899, reprinted in *The Med. J. Australia. Feb. 13, 1960.*

Surgical Management of Cerebrovascular Insufficiency

Cook County Hospital

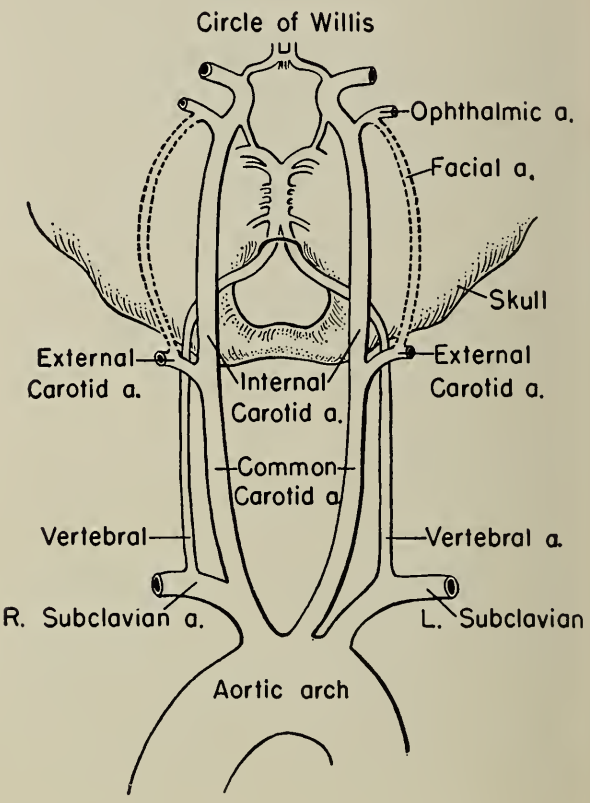
Moderator:

Robert J. Freeark, M.D.
Director of Surgical Education, Cook County Hospital

Discussant:

Ormand C. Julian, M.D.
Professor of Surgery, University of Illinois College of Medicine; Attending Surgeon, Presbyterian-St. Luke's and Illinois Research Hospitals

Dr. Robert J. Freeark: Our subject today deals with an age-old problem which has recently undergone intensive reevaluation and some rather dramatic attempts toward its solution. As you know, the scope of vascular surgery in the last 10 years has been practically boundless. After demonstrating truly remarkable progress in the correction of the life-endangering disorders of the heart and major vessels, the vascular surgeon next tackled the extremities and began concentrating upon the salvage of patients' limbs. The results were often little short of miraculous. Each conquest seemed to launch an entirely new field of endeavor. Now we find him attacking surgically the problems of circulation to the brain in a very ingenious and intrigning fashion. Whether you call it surgery of the carotid vessels, management of cerebral ischemia, or surgery for cerebrovascular accidents, the objective is quite clear. He has embarked upon an attempt to do something for those unfortunate patients who have experienced or are heading for a "stroke." Medicine has for years recognized the warning signs of this impending catastrophe. In some instances we now can do something to forestall it.



The cerebral circulation

This migration of the vascular surgeon from the thorax, abdomen and extremities to the region of the head and neck necessitates a brief review of the anatomy and principles involved in the cerebral circulation. To assist in the discussion we have drawn on the blackboard (Fig. 1) a rather diagramatic representation of the circulation to the brain. Lest our speaker be called upon to account for my inadequacies as an artist, let me emphasize certain anatomic points.

You will note the brain derives its chief blood supply through the internal carotid and basilar arteries which eventually communicate within

the skull at what we have termed the circle of Willis. A significant additional source of collateral circulation is provided by the external carotid artery which has a key anastomosis with the internal carotid-basilar system in the region of the orbit (opthalmic frontal anastomosis). These anastomoses are often inadequate to maintain circulation to the brain cells when an internal carotid artery is occluded. As you recall, the cells of the central nervous system are the most sensitive in the body to anoxia. The period of time that one may occlude this circulation varies with a number of factors, but I think it would be fair to say that brain cell function stops after 5 minutes of complete anoxia and is probably irreversibly altered after several more minutes. While most occlusions do not completely interrupt all the arterial flow to an area of the brain, it is immediately obvious that the vascular surgeon has two special problems when dealing with the cerebral circulation: (1) the extremely short period of time within which he must effect his restorative procedures, and (2) selecting patients for surgical treatment who have not as yet undergone irreversible damage but seem headed in that direction.

This, then, is the problem. If there is one man who has made strides toward its solution it is Dr. Ormand Julian. He is one of the outstanding cardiovascular surgeons in this country and the world. His contributions and accomplishments in the field of vascular surgery are well known to most of you and are a matter of record in the surgical and medical literature of the past two decades. Last year on his visit with us, he demonstrated at one of these Conferences the wide experience, scientific background, and surgical acumen for which he is famous. In addition, he proved himself a very entertaining and able teacher of the difficult subject with which he is concerned.

We will begin with the presentation of the first case.

Case 1.

Dr. Edward Beheler, surgical resident: This 33-year-old white male was admitted to the medical service on July 10, 1959, in a semicomatose state with evidence of a left hemiplegia. The history was limited to a few incoherent mumblings about being kicked in the neck approximately one week previously.

On physical examination the head was found markedly deviated to the left. Attempts at movement elicited a painful response. His blood pressure was 120/80 mm. Hg, pulse rate 144 per minute, respirations at the rate of 60 per minute and temperature 103.2°F. Significant physical findings included evidence of a severe bilateral pneumonitis. There was evidence of a flaccid paralysis of the left upper and lower extremities with a positive Babinski on this side. Total paralysis of the entire left side of the face was present. The eyes were deviated to the right; the pupils were round, equal, and reacted to light and in accommodation. There was no external evidence of cranial or cervical trauma. The common carotid and superficial temporal artery pulsations were present bilaterally.

A spinal puncture made shortly after admission revealed an opening pressure of 110 mm. of water with a clear fluid. Roentgenograms of the skull and cervical spine were reported negative.

Three days after admission neurologic deficit persisted, although the sensorium had cleared markedly. Pneumoencephalogram and right carotid angiogram by the percutaneous method were carried out with somewhat equivocal results. Approximately one week later a limited exploration of the neck at the level of the right carotid bifurcation revealed a thrombosis of the internal carotid artery.

Dr. Freeark: Perhaps we should see the x-ray films before we begin the discussion.

Dr. William Meszaros, director, department of diagnostic radiology: The pneumoencephalogram showed the ventricular system normal in size and position. The common carotid arteriogram was made by percutaneous injection of 50% Hypaque®. It showed, on the posteroanterior view, the vessels of the scalp but not the internal carotid artery or its branches. This might be due to the fact that the needle was in the external carotid vessel by mistake, but on the lateral view the true state of affairs is visualized. The external carotid artery is seen, and at the base of the film you can see the internal carotid is occluded at its origin so that there is no filling of the distal portion. There is complete occlusion of the proximal portion of the internal carotid artery about 1 cm. distal to its origin from the common carotid vessel.

Dr. Freeark: The history of trauma in this case was developed largely after the patient's sensorium recovered. Thus, the pneumoencephalogram and the numerous skull films were done initially for diagnostic purposes. When a reliable history was obtained and the findings of the arteriogram were available, exploration was carried out some two or three weeks after the injury. The patient showed very little recovery from his hemiplegia at the time of surgery, although the sensorium had cleared. Before discussing the operative procedure can you, Dr. Julian, give us some advice as to whether we can help this man? Could we have helped him on admission had we known the true state of affairs?

Dr. Ormand C. Julian: Let me begin by reviewing the pathogenesis of this man's hemiplegia. Closure of a peripheral artery after trauma is a fairly well recognized pathologic occurrence; but it is not necessarily a well recognized clinical occurrence, even when it occurs out in the extremity where you can establish the absent pulse distal to the obstruction. There are many instances of acute arterial occlusion in which the interruption of arterial flow is difficult to detect because this kind of trauma (a direct blow) produces obstruction of an artery without evidence of hemorrhage. The lesion is best termed an intramural hematoma of the vessel. This is a very good term because the trauma apparently moves the layers of the vessels one on the other, interrupting the vasavasorum and permitting communication between the lumen of the vessel and the space below these layers, so that bleeding occurs into the wall of the blood vessel. When we look at sections from such an artery, we can see the hematoma in the wall of the blood vessel some place in the media.

Occlusion of the lumen results because the mass of the hemorrhage or hematoma flattens the two intimal surfaces together. Complete occlusion of the lumen may not occur at the time of injury; it may just be narrowed. We have two patients in whom occlusion occurred years after a fracture of the femur. The narrowed lumen finally occludes, however, so it does not make much difference in our history that we do not know when this patient was injured; it could have occurred a week before admission, and complete occlusion of a vessel in the neck may have occurred at any time thereafter. What is more important is to know how long he had had cerebral manifestations of acute occlusion. This information would aid in deciding how much effort should be extended in trying to disocclude the internal carotid artery.

If, at the time of surgery for cerebral ischemia, the internal carotid artery is found completely occluded in a patient whose symptoms are chronic, we have not had success in opening the artery. If the artery is found to be incompletely occluded, restoration of blood flow is possible in the majority of cases. But some place in between these two pictures — the bright and dark one — there must be a number of patients who could be operated on immediately after complete occlusion.

In this patient at least three days had gone by since complete occlusion manifested itself by hemiplegia. I would think it unlikely that the artery could be opened up. This artery in a 33-year-old male has undoubtedly been occluded by trauma without any external hemorrhage. It happened that the occluded artery is one that leads into the skull where a pulse cannot be palpated. This makes it more difficult to detect than if it had been a femoral artery. Nevertheless, the picture is the same, and the mechanism is probably an intramural hematoma in the wall of this artery. Following occlusion, thrombosis will occur distal to this point, probably as far as the circle of Willis.

The patient could probably never be restored to normal as far as his circulation is concerned because this artery had probably been occluded for too long a period. It would be hard to know how much good would have been accomplished had his carotid been opened this long after the cerebral damage. Occasionally it might be of benefit in relieving some of the clinical manifestations; but this certainly would not be extensive, and it would not be a very hopeful picture.

The trauma in this patient must have been to the internal carotid artery. There is some indication that this is so by the fact that there is a low bifurcation of the carotid, because the branches of the external carotid are low in the neck, as seen on the arteriogram. It was just bad luck for this person to have been kicked exactly in that place and to have such a low origin of his internal carotid artery.

Dr. Freeark: In such a case should we be reluctant to do an arteriogram? Would it do any harm?

Dr. Julian: I think you do not need to do it. The next time you encounter a patient with trauma to the neck, he will have the injury to the common carotid artery and you will be able to find it because the temporal pulse will be absent, and the loss of pulsation of a vessel above the site of injury will tell you that the carotid artery is occluded. There will not be much point in doing an arteriogram. If you do an arteriogram proximal to the obstruction, it will not tell you the state of the internal carotid artery beyond the obstruction because this vessel would not be filled. You would not do an arteriogram in such a case, and I would certainly explore the vessel in the neck. I think you should disregard the history of how long it has been occluded if you know there is complete occlusion of the common carotid artery. The common carotid will be occluded far enough away from its bifurcation that there is sufficient circulation to keep the vessel open through the external carotid anastomosis with the opposite side via the lingual and the superior thyroid vessels.

I would explore such a patient, even though he had hemiplegia, in the hope that I might improve this collateral circulation by opening up or by-passing the site of occlusion. In some cases the cellular dysfunction may be only partial and reversible with improved circulation. You would have the most hope of helping the patient within 30 minutes of onset of hemiplegia and diminishing hopes after that. Exploration would not be dangerous because it would be done under local anesthesia.

Dr. Freeark: What about the ophthalmodynamometer and other means advocated for detecting this internal carotid thrombosis?

Dr. Julian: Actually an attempt to palpate the internal carotid artery pulse in the posterolateral wall of the pharynx can be a helpful maneuver. My only criticism of it is that I may not be able to be sure that the pulse is absent. Occasionally you can feel a thrill over the internal carotid artery region in the neck, or perhaps you hear a bruit in this area. All of these possibilities should be investigated. The ophthalmodynamometer is very helpful as a tool in some of these cases. The instrument permits an evaluation of the pressure in the retinal artery, which is a branch of the internal carotid system. By the application of measured pressure on the ocular globe, one may establish the amount of pressure required to occlude retinal artery pulsations. There is no normal retinal artery pressure, but it is the difference on the two sides that is significant. A lowered retinal artery pressure on one side suggests internal carotid occlusion.

Dr. Freeark: I believe that Dr. Champ Lyons reported a case of hemiplegia of 10 days' duration that he restored successfully by thromboendarterectomy of the internal carotid. Certainly some hemiplegias recover spontaneously, but the result in his case was truly dramatic. He, too, prefers to treat them within minutes of the occlusion, however. Do you think with 10 days having elapsed we should try it?

Dr. Julian: I think you should try, but I would not hold out much hope.

Dr. Beheler: Is the vessel that occludes from hemorrhages in the media useful again?

Dr. Julian: The vessel is destroyed in this situation and quite thoroughly destroyed (illustrating at blackboard). The give-away is that the vessel is always expanded in the area of the contusion. In treatment you have to remove the involved area; nothing else will do. It has to be removed a fair distance away from the place where the vessel begins to look or feel abnormal, because hematoma may extend quite a distance from the site of the gross lesion.

Case 2.

Dr. Paul O'Brien, surgical resident: This 64 year old white female was admitted to Cook County Hospital on July 22, 1959, with a minor laceration of the scalp sustained during a fainting spell. It was learned that she had had similar fainting spells for the past 5 years; this was confirmed by her employer and subsequently observed on the ward. The attacks were variously described as consisting of bizarre motor behavior, such as walking in a circle with the arms outstretched, or as a single faint with periods of amnesia.

Physical examination disclosed a blood pressure of 150/80 mm. Hg, pulse rate of 96 per minute, respiratory rate of 16 per minute. Her general condition appeared good. The heart and lungs were within normal limits for the patient's age. There was no evidence of neurologic deficit or abnormality of the ocular fundi. Peripheral pulses were intact throughout with the exception of an absent left carotid pulsation.

Laboratory studies revealed normal electro-

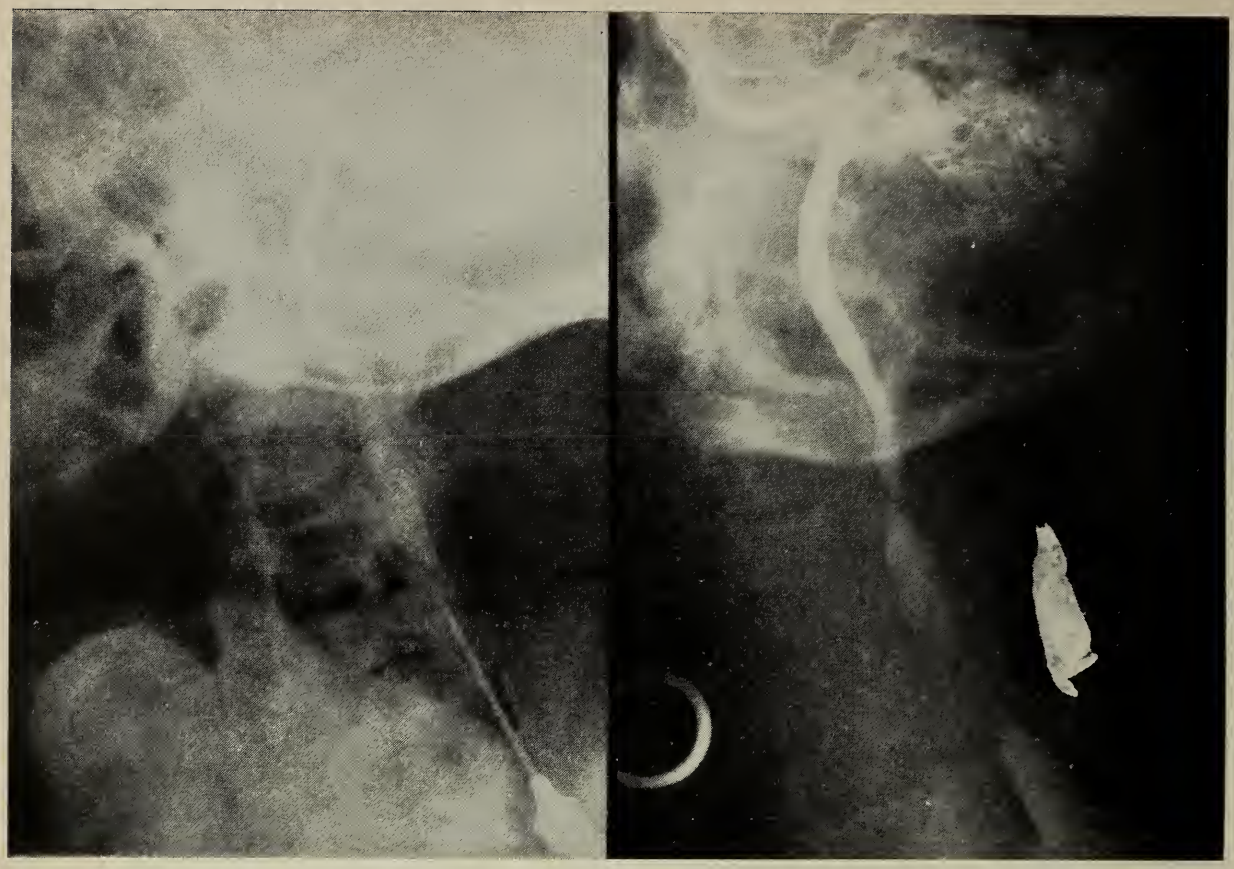


Figure 2. A typical example of internal carotid occlusion. Pre- and postoperative arteriograms.

cardiogram, electroencephalogram, liver profile, urinalysis, and hemogram.

On July 28, 1959, a retrograde left brachial arteriogram showed no filling of the left common carotid artery. The left vertebral artery appeared normal. Further diagnostic studies were undertaken and surgical intervention was proposed. However, reevaluation on Sept. 18, 1959, showed that the left carotid pulse was now palpable.

Dr. Freeark: This patient was investigated by the service on the suspicion that she was having "little strokes" based on cerebral ischemia. The chief complaint of intermittent "spells" suggested that certain critical areas of the brain were receiving only a marginal blood supply. During certain periods of the day this blood supply became inadequate for cellular function. However, since recovery without neurologic deficit always occurred, it was assumed that the ischemia was not severe enough to cause cell death or irreversible brain damage. With the detection of the absent left carotid pulse, we were encouraged by the prospect that her cerebral ischemia was on the basis of an occlusion of the extracranial carotid vessels which might be dealt with surgically by endarterectomy or by-pass procedure. This was the basis for the retrograde brachial arteriogram in which the brachial artery was catheterized and the catheter advanced toward the heart in an attempt to visualize the entire common carotid artery on injection of the contrast media.

We were somewhat distressed by two aspects of this patient's clinical history: (1) The long duration (5 years) of ischemic symptoms without a major stroke having occurred, and (2) the sudden reappearance of a previously absent carotid pulsation.

Dr. Meszaros, will you review the arteriograms for us?

Dr. Meszaros: In this case the contrast media was injected through a catheter advanced into the arch of the aorta. The left subclavian and the vertebral artery are well visualized and appear normal. We do not see any evidence of a carotid artery at all, and we initially felt that this was good evidence of occlusion of the common carotid at its origin because almost always

we see some filling of the carotid. There remains, however, the distinct possibility that the catheter was not advanced far enough into the arch of the aorta to permit visualization of this vessel. With the return of pulses in this vessel we became suspicious that this might be the case.

Dr. Julian, how far should we go in saying there is evidence of occlusion of the carotid when we do brachial arteriograms and see no contrast media in the carotid?

Dr. Julian: The carotid artery might be open, and it could be missed on this arteriogram. Unless the tip of the catheter gets into the aorta or even across to the right, the orifice of the carotid could miss any dye that escapes because of the rapidity of the flow at this level. Whether it does escape it or whether this is good evidence of occlusion I do not know. We do not do left carotid angiograms in this way.

This is an unusual case. I have never seen anyone who did bizarre things as the result of occlusive carotid disease. We have wondered if somebody would not some day show some kind of unusual behavior pattern, such as walking in a circle, on the basis of arterial insufficiency. Fainting is a frequent finding, but the other is infrequent.

The presence or absence of a carotid pulse is sometimes a difficult thing to determine, particularly in an old person, because the carotid may curve a little and hide itself a little and you will feel and feel and not find it. Then all of a sudden, you get it trapped and have a good strong pulse. The thing is rigid and unless you have it trapped against something, you do not feel it pulsate. It seems ridiculous that the carotid pulse should be questionable, but it is. This may account for your changing physical findings.

The subject under discussion today is the surgical management of cerebrovascular insufficiency. You might call this the preventable cerebrovascular accident. This second patient has not had a cerebrovascular accident yet in the sense of permanent brain damage. What she perhaps has is intermittent attacks of cerebral ischemia, probably more marked on one side than the other, and she is about to have a stroke. If we can find the place where the artery is obstructed, it may turn out to be a place that will be operable; therefore, it will be a preventable cerebrovascular accident.

I have a few slides I would like to show to emphasize some of the points made today. At the moment I would confine my remarks to the carotid system. The vertebral system also contributes much to the cerebral circulation, but this discussion will be concerned largely with occlusions of the internal carotid artery. These patients have intermittent attacks; in other words, the symptoms of occlusion occur intermittently while the occlusion is probably constant. Even partial occlusion produces intermittent symptoms and signs of headache, weakness, confusion, nervousness, dizziness, and a very constant complaint of feeling tightness around the head. This is surprisingly constant from patient to patient but is intermittent in the given individual. The right leg and right arm may become weak; there may be disturbance of speech. Transient blindness has occurred some 10 times in our group of 51 patients. Fainting with complete loss of consciousness is a characteristic feature.

The diagnosis of internal carotid occlusion should be considered in the presence of symptoms of cerebral ischemia associated with:

1. Bruit and/or thrill over the carotid bifurcation in the upper neck.
2. Decreased retinal artery pressure as measured by the ophthalmodynamometer.
3. Positive carotid compression test.
4. Absence or diminution of internal carotid or superior temporal artery pulses.
5. Radiologic evidence of arterial occlusion.

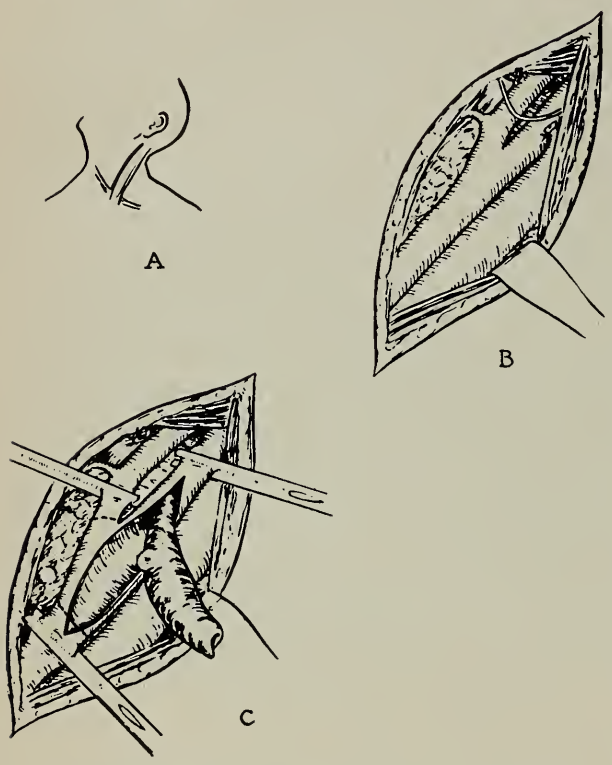
Table I summarizes our results in surgery of the carotid artery. We have divided our patients into three categories. There are 38 patients in Category I. All have had transient episodes of cerebral ischemia manifested by unilateral sensory or motor changes. Visual symptoms have varied anywhere from fogginess of vision to temporary blindness. Aphasia occurred when the artery to the dominant hemisphere was affected. Patients in this group are ideal candidates for direct arterial surgery. In this series of 38 patients, blood flow was restored in each one, and 33 have remained asymptomatic.

Figure 2 shows a pre- and postoperative carotid arteriogram after removal of a calcified plaque (shown on picture); blood flow was restored and symptoms relieved.

Endarterectomy has proved highly successful in the treatment of localized lesions of the carot-

id bifurcation. Figure 3 demonstrates the technic of endarterectomy which is done under local anesthesia.

Figure 3



By-pass grafting is indicated where the lesion is more extensive and has been used in 13 patients in our series (Fig. 4).

Patients in Category II have a past history of a stroke and have residual neurologic abnormalities. We have not been able to restore blood flow in any of the 7 patients operated on.

The clinical picture of patients in Category III is difficult to evaluate. There is evidence of mental deterioration, bilateral neurologic abnormalities, and radiologic findings of multiple occlusions. Four patients had two-stage operations. Blood flow was restored in all and resulted in significant improvement in 4; 1 patient died and 1 is unchanged.

Dr. Freeark: You said you are not using a retrograde brachial arteriogram. How do you do it?

Dr. Julian: We do a percutaneous common carotid puncture.

Dr. Freeark: Do you use the ophthalmodynamometer?

Dr. Julian: Yes; it is a valuable instrument and it is very easy to use. The pressure is applied to the globe through the lid, and the end points in reading it are very sharp.

Dr. Freeark: Could you explain again how it works?

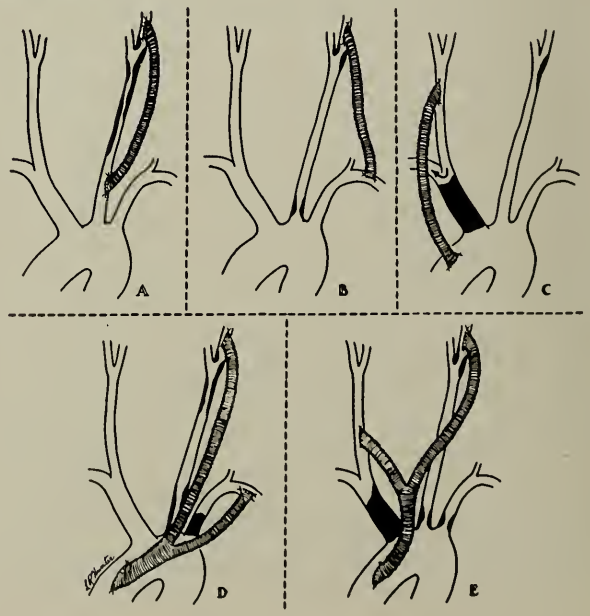
Dr. Julian: You apply a known amount of pressure to the globe through the sclera. At the same time you watch the vessels inside the fundus, measuring the amount of pressure it takes to stop pulsation and noting how much it takes to empty the arterioles. This gives you the systolic and diastolic pressure in the retina. You then compare the two sides. The instrument reads in millimeters of mercury.

Dr. Freeark: You are actually measuring ophthalmic artery pressure by assessing the pressure in the retinal artery. The ophthalmic is a branch of the internal carotid artery. If the internal carotid artery is completely occluded, do you have a retinal pressure of significance?

Dr. Julian: Yes, because of the collateral circulation from the opposite side or the external carotid on the same side.

Now I would like to show you a movie which will illustrate some different ways of surgical approach. The picture begins at the time of surgery. You will see the characteristic enlargement of the internal carotid artery, which is very soft above and below but hard in the middle where it is occluded. The only thing that is time consuming is that sometimes the intima at the top may be thickened. If it is, it must be tacked down with fine silk suture put in through the wall of

Figure 4



the vessel. We do not close the vessel over a catheter because there is lots of room in which to work.

In this movie you will see what we do when there is obstruction in the region of the common carotid artery. This occurred eight times in our series. The patient in question had a right hemiplegia and had been having subsequent little strokes. Her family doctor found nothing but gallstones; so they took out the gallbladder and she had her stroke while under the anesthetic. The common carotid and internal carotid arteries were occluded. When this occurs, thrombosis advances up the entire internal carotid as far as the first major bifurcation within the skull. The offending thrombus was removed, but little evidence of back bleeding was obtained. We worked for a reasonable time with suckers and tubes and could never get a back flow; so we clamped it.

This is the kind of case we have struck out on each time, that is, when there is complete occlusion of the internal carotid. It is conceivable that someday with a good method of getting control distally inside the skull, one might try even harder to clear out the entire internal carotid from the neck side. As it is now, you can visualize how you might perforate the artery within the skull or even push the clot in front of the instruments up into the skull so that it might go both ways in the circle of Willis and make the situation worse. If we could get a flap raised on the side of the head and identify and isolate the internal carotid inside the skull, there might be some future for this kind of case.

QUESTION: Do you ever use a vasodilator such as papaverine in partial occlusion?

DR. JULIAN: No. A good many of the patients we see are asymptomatic when we see them. We get the history of their "little strokes," make observations that are objective, and go ahead and operate. So far as vasodilators are concerned, I might say that at one time or another we do a stellate block through the wound and put a lot of novocaine around the stellate ganglion.

DR. FREEARK: Have you operated on an acute cerebrovascular accident within the first few hours?

DR. JULIAN: No, we haven't yet. Dr. Reynolds at the old St. Luke's Hospital did one within four hours and the patient's hemiplegia was not immediately better, nor did he recover completely even afterwards.

QUESTION: Do you use anticoagulants?

DR. JULIAN: Yes, during surgery we put a little heparin and saline into the internal carotid. We usually use 20 to 40 mg. of heparin subcutaneously every 3 to 6 hours after surgery, depending upon the size of the patient, and so on. We discontinue this before the patient leaves the hospital.

QUESTION: With a history of constant headache and hypertension but no other findings except fainting spells, would you think a patient would be a candidate for such a surgical procedure?

DR. JULIAN: No. I don't think those three things would particularly lead you to operate on the patient, but they would lead you to do a complete vascular work-up during which you would listen to the carotid, and if you found a bruit you would wonder whether to operate or not. We have patients in whom the problem is not what to do but which to do first. I would not put any age limit on this procedure; our oldest patient is 77.

DR. FREEARK: Dr. Julian, once again we have had a most profitable hour. You have more than fulfilled the promises of your performance last year which we enjoyed so much, and we thank you kindly for your excellent presentation.

For the benefit of the house staff, we have prepared a summary of this subject. It may prove helpful as a review or to clear up any additional questions on material presented.

Points to Remember in Surgical Management of Cerebrovascular Insufficiency

1. The brain, like the myocardium or muscles of the leg, may manifest symptoms of ischemia which are transient, reversible, and constitute a prelude to infarction or encephalomalacia.

2. While these symptoms may arise from atherosclerotic narrowing of the intracranial arteries, a large percentage are on the basis of plaques in the extracranial segments of the carotid and vertebral vessels.

3. Occlusive disease of the carotid system is usually (90%) found at the bifurcation of the common carotid. An involvement of the carotid at its origin from aorta or innominate artery accounts for the remainder. The cause of the disease is atherosclerosis, and occlusion results when a small plaque in the intima ulcerates, becomes

involved with clot, and enlarges to produce stenosis or occlusion.

4. The severity of symptoms produced are determined by the:

a) Location of the occlusion (common or internal carotid).
b) Extent of completeness of occlusion.
c) Degree of collateral circulation in the intracranial vessels (circle of Willis).
d) Degree of collateral circulation through the external carotid vessels (facial artery to ophthalmic artery).
e) Status of vertebral arterial circulation.
f) Changes in systemic blood pressure (e.g., myocardial infarction or postural hypotension may precipitate attacks).

5. The diagnosis should be considered in the presence of *episodic neurologic symptoms,* especially in association with abnormalities of the carotid pulse, or murmurs or thrills at the carotid bifurcation. The neurologic symptoms may consist of blindness, aphasia, paralysis, paresthesias, or impairments of consciousness.

6. In addition to auscultation of the neck and careful neurologic examination, the physical examination should include a search for pulses and determination of blood pressure in both arms to detect involvement of other branches of the aortic arch. The response to contralateral or ipsilateral carotid occlusion by digital pressure should also be recorded.

7. Since no method of palpation of pulses in the neck serves to identify internal carotid occlusions, frequent recourse to arteriography is essential in patients with the "little stroke" syndrome.

8. The major indication for surgical intervention is symptoms of cerebral ischemia *without evidence of infarction.* The following generalizations are possible:

a) Patients with obstructing lesions of the arch of the aorta, regardless of extent, and all of those with partial lesions of the internal carotid artery are favorable candidates.
b) Patients with complete occlusion of the internal carotid are not candidates unless explored within a few hours after the onset of symptoms.

9. Surgical treatment involves the use of thromboendarterectomy in which the inner diseased portion of the arterial wall is removed or by-passed with an arterial graft.

10. Supportive measures during surgery include:

a) Minimal anesthesia and premedication.
b) Hypothermia to minimize effects of cerebral ischemia.
c) Temporary shunts around the diseased artery using polyethylene tubing and large bore needles.

Prevention and Early Detection Of Chronic Illness in the Aged*

Henry T. Ricketts, M.D.**, *Chicago*

It is appropriate to start this discussion with a list of the principal chronic diseases to which aged individuals are prone:

cardioviscular disease	nutritional disorders
cancer	impaired vision
diabetes	deafness
arthritis	prostatism in men

mental and emotional disturbances

A moment's reflection brings the realization that only one or two of these disorders are limited to the aged. Most of them are seen in childhood, and even atherosclerosis, especially of the coronary arteries, occurs in men in their twenties. Thus, the prevention and early detection of chronic illness are not confined to geriatrics but are a part of good medical care in all age groups. This is not to deny that the diseases we have listed are more common in old age, that the *milieu* in which they occur may be rather special, or that their manifestations and indeed their treatment often are influenced by age.

Prevention

How can these chronic ailments be prevented? We are speaking now of primary prevention, the prevention of the occurrence of disease, not secondary prevention by which we seek to avoid the progression or complications of existing disease. We are dealing with well people who must be told what to do to avoid becoming ill. How do we reach well people? Rarely through individual doctors, for most people who go to a doctor are already ill. Whatever we have to tell the public must be broadcast widely by sources of health education such as medical societies, voluntary health organizations, and governmental health departments. And it must be conveyed in time to do some good, which means when people are young or middle aged, not already old. Some will listen. Many more will not, and this constitutes our first obstacle.

The second is that we don't know much about the prevention of chronic illness because we don't know much about its causes. What we do know, of course, we should pass on to the public, but we must be careful to tell them facts, not theories. Take arteriosclerosis, the chief enemy of the aged. Can we state with any certainty what causes it? It is now well established that the substitution of polyunsaturated fats for animal fats in the diet lowers serum cholesterol levels; but, despite much direct evidence in animals, it is far from proved that excessive concentrations of cholesterol in the blood actually produce atherosclerosis in man. Are we then jusified in advising the public to avoid animal fats from childhood on?

The close association between coronary disease and cancer of the lung, on the one hand, and heavy cigarette smoking on the other has been amply demonstrated even though a causal relationship has not been fully proved. The public should know these facts. They should know, too, that excessive sunlight causes skin cancer in some individuals and that chronic irritants may induce cancer in various places as tobacco does in the mouth. But we cannot as yet give any rules for the avoidance of malignancies of, for instance, the breast, gastrointestinal tract, and prostate.

With the rapid advance of knowledge in the field of diabetes, we may be on the threshold of discovering how to prevent the disease in those predisposed to it by heredity. Today, however, we can only caution against obesity in the hope that maintenance of normal body weight will postpone, if it does not forestall forever, the onset of glycosuria. Both obesity and its opposite,

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**Professor, Department of Medicine, University of Chicago; Chairman, Board of Governors, Institute of Medicine, Chicago; Member, Committee on Aging, Illinois State Medical Society.

malnutrition, so common in the aged, are particularly amenable to public health education, and much is being done already to inform our citizens on these subjects.

The mental disturbances of old age are especially distressing. In many cases they are the result of organic disease, either in the brain or elsewhere, and their prevention, if possible at all, is the prevention of the underlying disorders, if this is possible. The prevention of some of the primary psychoneuroses must of course begin in early life, for we can do nothing about it when the person is eighty. In other cases the emotional disturbances that naturally occur with the death of a spouse, the passing of old friends, the loss of physical faculties, and the threat of economic insecurity present difficult problems that can be met only in part by the active support of the remaining family and the sympathetic attention of a physician, minister, or social worker.

I have said enough to indicate that, with some exceptions, we do not have the knowledge to do an effective job of preventing chronic disease in the aged. The crying need is for research into its causes, and despite wide-spread interest and activity, research is slow in producing results. Meanwhile, an enlarged program of health education will keep at least a portion of the public abreast of developments.

Early detection

The early detection of disease is important not only because some conditions can be cured but also because some that are not fully curable can be prevented from progressing. Blindness, for example, often can be avoided in glaucoma and vascular complications in diabetes.

In the detection of incipient chronic disorders, as in their primary prevention, public health education must play a leading role. People must be taught the warning symptoms of disease, but in such a way as not to alarm them; and they must be urged to see a physician if such symptoms appear.

Perhaps this is the place to make the point that the doctor's office, or the clinic, is the best detection center we have. There is no substitute for personal contact between the individual physician and the individual patient. The problem is to get the two together.

Ideally, of course, disease should be discovered before it produces symptoms. If this were followed to its logical conclusion, it would mean that everyone should have a physical examination and various laboratory tests at least once a year. Obviously this is impossible. Never will everyone do it, and if everyone did there would not be enough doctors to go around. There are other drawbacks to the annual "check-up" for all apparently well people. While many disorders can be picked up early by simple methods, there are others such as internal cancer that will be missed unless expensive x-ray and ancillary procedures are employed. And even with these, very small lesions may be overlooked. Moreover, there can be no assurance that a disease process will not begin within a month or so after a completely negative examination. Finally, a false sense of security engendered in the individual who has passed such a survey may prevent him from seeking medical advice for symptoms that appear later. These criticisms of the wholesale annual "check-up" are cited not to discourage its expansion, for it could be used more widely than at present, but to point out that it has limitations that should be recognized.

Multiple screening procedures on a mass basis have been attempted as one solution to the problem. The tests have included a chest x-ray; blood samples for syphilis, diabetes and anemia; urinalysis; and measurements of height, weight, vision and hearing. Such screening unquestionably has detected a significant amount of unsuspected disease, but it too has serious disadvantages. Its greatest success has been in selected, almost "captive," population groups, and its extension to the public at large is nearly as impractical as is the universal physical examination. Smillie[1] states that negative results are obtained in about 960 individuals out of 1000 subjected to multiphasic screening. Comprehensive mass testing is thus very expensive in relation to positive cases found. Furthermore, although these procedures have about reached the limit of feasibility in terms of completeness, cost, and time consumed, they still leave many areas of potential disease untouched.

Screening is worthless unless there is effective follow-up by which positive cases are referred to physicians. Experience has shown that many screenees have no physician to whom they can be referred. Of those who do, a variable and often disappointing fraction follow the advice of the screening center that he be consulted.

Of those who do consult their physicians, a further variable and discouraging fraction fail to receive the proper additional examination.

Parenthetically, the most successful mechanism for the mass detection of chronic illness, aside from serologic tests for syphilis, has been the mobile x-ray unit with its limited objective, originally, of finding a communicable disease—tuberculosis. Its later application to the diagnosis of other lung lesions and heart disease has been practical because it has involved no additional technics.

Physician's role

We return, then, to the physician as the keystone of the early detection of chronic illness. Among the inhabitants of institutions and homes for the aged for whom he is responsible, there is a ready-made opportunity for him to carry out "multiphasic screening" in the best and most complete sense of the term, i.e., by taking a careful history, performing a good physical examination, and ordering the standard laboratory tests of blood and urine, with more elaborate procedures as indicated. Of the old people outside of such homes and institutions he can reach only those who come to him voluntarily because of symptoms or because of pressure from families or the persuasion of health education programs. The finding of incipient disease in such persons, again, begins with the usual history and physical and laboratory examinations that characterize good medical practice. Areas that should not be neglected, particularly in the elderly, are social history, food habits, mental status, cardiovascular appraisal including an electrocardiogram, pelvic and rectal examinations including proctoscopy, measurement of body weight, and tests of hearing and vision. Routine laboratory procedures should include a chest film, a postprandial blood sugar determination, and tests for occult blood in the stools. All of these, it should be noted, can be done at only moderate expense, and most of them in the physician's office.

If the doctor is, as we have said, the key figure in the early detection of disease, we must see to it that he is frequently reminded of his obligation and exhorted to practice his art with preventive aspects constantly in mind. Professional education, then, is just as important as public health education in the war against chronic illness; and medical societies such as this have the opportunity and the duty to keep their members interested and informed.

The role of the medical profession, however, needs to be considered at a much earlier stage than this. The growth of preventive medicine will require many more physicians than we have now. Today's doctors are more than busy taking care of the sick, and we are going to have more of the sick as our citizens become both more numerous and older. If it is true that the periodic examination of the well—even a sizeable fraction of them—and the early detection of incipient disease need to be done on a larger scale, then we must increase the number of our medical graduates. In this country, among a population of roughly 170 million we have 30,000 medical students. In Russia, with a population of approximately 200 million, there are 150,000 medical students, or five times our number. To what extent these will be used for preventive purposes is difficult to say, but the man power will be available. Certainly the cost of a greatly expanded program of medical education in the United States would be enormous, but it is enough to point out that the Russians have managed it. Furthermore, they pay their students instead of charging them.

Community program

What can be done on a community level? Perhaps the most effective mechanism is the establishment of programs of health education. This can be initiated and backed by the county medical society, but here a word of caution is in order. It must be done quietly. A flamboyant campaign by the profession would be both undignified and suspected by the public as a bid for business. What is needed is a lay organization of prominent citizens that can take the lead, with physicians supporting the program behind the scenes.

The media that can be employed to reach the public include radio and television broadcasts; articles in the local newspapers; posters and literature placed in strategic places; and lectures by outside medical speakers before church groups, Rotary, Kiwanis, and parents' associations. It is a pity that advantage is not taken oftener of the visiting lecturer to the medical society who could just as well address a lay group on some health subject at a different hour.

Much can be gained by utilizing informational material of national voluntary health organizations such as the American Heart Association, The American Cancer Society, and others. The annual diabetes detection campaign, sponsored by the American Diabetes Association and emphasizing case finding and education, not fund raising, lends itself admirably to community exploitation.

Finally, don't forget the local health department. Many doctors look with suspicion on the growing activities of governmental health agencies, be they federal, state, county, or city; and I admit that in some areas suspicion is justified. I see no menace, however, in the participation of health departments in the informational aspects of public health education; and certainly, so far as the detection of communicable disease is concerned, their cooperation is not only desirable but necessary.

Summary

To summarize, the primary prevention of most chronic illness awaits the discovery of its causes. The early detection of chronic disease, in the last analysis, remains the responsibility of the individual physician. If he is to play his proper role, two things must happen: (1) People must be educated to seek his services, if not prophylactically, then when ostensibly minor symptoms appear; and (2) we must train many more physicians in proportion to our population. Meanwhile, much can be done at the community level by the laity, by the profession, and by local health departments to further the public's understanding of disease to the end that the meaning of symptoms may be appreciated and medical advice sought before it is too late.

REFERENCE

Smillie, W. G.: Multiphasic Screening Tests, J.A.M.A., 145:1254, 1951.

Diabetes and alcohol

It is interesting to note that none of our present authorities have definitely prohibited alcohol in diabetes. Joslin, whose views on alcohol may be extreme, occasionally allows certain patients to have it, provided they take no more than 2 oz. of whisky daily and that they consider its caloric content. He recognizes that alcohol is not converted into sugar or acetone in the body, but does produce a return of glycosuria and other symptoms when added to the diabetic diet in quantities exceeding caloric tolerance. Some internists advise caution with champagne and cocktails which are high calorically.

All physicians who tolerate social drinking among their diabetic patients should be careful to warn them about the difficulty of differentiating insulin shock from alcoholic symptoms and should also advise them to carry credentials which would make their condition known if they should collapse unexpectedly with alcohol on their breath. *Matthew Ferguson, M.D. and Sister Michael Marie, M.D. Alcohol in Clinical Medicine. GP January* 1960.

Togetherness

I am reminded of the lady psychiatrist at the theater who suddenly felt herself being pinched by the man in the next seat. At first quite alarmed, she soon quieted herself by thinking: "Well, after all, that's his problem, not mine."

Universities, medical schools, and hospitals have been pinching each other for a long time; in fact, on occasions they have even been known to claw at each other. The time has passed, however, when either a medical school or its hospital can say to the other with respect to medical education: "That's your problem, not mine!"

I do not know whether the lady psychiatrist and her annoyer ever got married and made *his* problem *their* problem, but we do know that more and more medical schools and hospitals are being joined in wedlock, and thus officially making medical education, both undergraduate and graduate, their common responsibility. *Donald G. Anderson, M.D., Graduate Education in Medicine — Whose Responsibility? Boston Med. Quart. December 1959.*

Dietary Lipemia

And the Clearing Factor

H. Engelberg, M.D., *Los Angeles*

Most ingested fats, following absorption, enter the chyle and are discharged into the bloodstream via the thoracic duct in the form of large particles known as chylomicrons. The question of the exit of these micromolecules from the circulation is an intriguing subject on several counts. Physiologically, the organism faces the problem of the rapid removal of innumerable large fat globules dispersed in an aqueous medium, a problem which presents itself three times every day after meals. The situation is complicated by the fact that the capillary walls are relatively impermeable to chylomicrons whose molecular weight is of the order of several million. At the clinical level, there is possibly a relationship between disturbances in the normal pathway(s) for the removal of alimentary fat from the blood and the development of atherosclerosis. All published studies of fat tolerance have shown that, on the average, the rate of removal of a standard fat load is slower in atherosclerotic individuals than in matched normal controls. Thus, the increased serum lipids and cholesterol found in many coronary patients, and accepted by nearly all investigators as one of the important factors in atherogenesis, may well result from some defect in or malfunction of the normal fat clearing mechanism.

A brief description of the state of circulating lipids is obligatory in any discussion of mechanisms involved in fat transport. Lipids do not exist in plasma as isolated molecules of free or esterified cholesterol, phospholipid or neutral fat, but are bound together with protein in the form of complex lipoproteins. These lipoproteins form a spectrum of compounds of varying size and density, ranging from the largest particles of lowest density, the chylomicrons, down to the smallest particle of highest density. They can be separated grossly into A and B-lipoproteins by electrophoretic or chemical technics, and defined quantitatively by ulracentrifugal analysis into high and low density lipoproteins of varying Sf classes.

In general, chemical analysis of isolated fractions has shown that as one proceeds from the largest to the smallest lipoproteins, the percentage of total and esterified cholesterol, phospholipid, and protein is increased and the triglyceride content decreased. Following a meal containing fats, the blood is particularly rich in chylomicrons which predominantly contain triglyceride. The triglyceride functions as the major vehicle for the transport of esterified fatty acids in plasma with the most rapid turnover rate.

Enzymatic action

In recent years an enzymatic process, called the lipemia clearing factor, has been uncovered which may well play the major role in removal of postalimentary triglyceride from the bloodstream. Briefly, it was found in 1943 that heparin abolished alimentary lipemia in vivo.[1] It was demonstrated that postheparin plasma cleared lipemia in vitro. The nature of the lipid alterations involved in "clearing" was understood when it was observed that chylomicrons and the larger low-density lipoproteins rapidly disappeared from the plasma with a concomitant loss of fat from the bloodstream following injection of heparin.[2]

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the author and do not necessarily represent the official view of that committee.

Subsequent investigation disclosed that a true lipolysis of neutral fat occurred with a splitting off of unesterified fatty acids and glycerol and the appearance of smaller, more dense lipoproteins. The essential function of albumin in this reaction as a carrier molecule for free fatty acid was then established. Finally, the active lipolytic substance was found in the hearts of normal rats and in the plasma of some human subjects[3] without prior injection of heparin, the lipoprotein nature of its substrate was defined, and it was more accurately named heparin-activated lipoprotein lipase.[4] The demonstration of the existence of the enzyme without the use of exogenous heparin established that it was not simply an interesting artificial phenomenon but normal substance in the body.

What of its function in fat clearing? Space does not permit more than an outline of voluminous evidence supporting this concept, but it has been more thoroughly presented elsewhere.[5] We may note the following major points. Heparin is apparently a component of the enzyme, and heparin is normally present in the plasma in substantial quantites (1-2 mg./L). Fat intake may stimulate lipemia clearing factor in animals and man. In some humans enough of this enzymatic activity has been demonstrated in the plasma to account for the removal of four to five grams of neutral fat per hour. In the majority it has not been found, but this can be explained by its functioning at the capillary wall and the interesting fact that the enzyme is itself inactivated during the fat-splitting process.

Lipemia clearing factor is present in the plasma in 10-20 per cent of humans, and it is qualitatively identical to the post heparin lipolytic enzyme in 90 per cent of these individuals. The low-density lipoproteins (high in triglyceride content) were statistically significantly decreased in those subjects in whom lipemia clearing factor was present in the plasma (651 mg.% vs 753 mg.%). Furthermore, circulating heparin levels were higher in patients with lower levels of the low-density lipoproteins. In animals and man anti-heparin substances such as protamine or toluidine blue cause an increase in lipemia and a delay in removal of fat from the bloodstream. Finally, the injection of radioactive labeled chylomicrons is rapidly followed by the appearance of most of the radioactivity in the plasma free fatty acids, suggesting an intimate relationship between the removal of chylomicrons and the lipolysis of their triglyceride component.

Two other possible pathways for chylomicron removal from the plasma have been suggested, the reticulo-endothelial system and the liver parenchyma. The former certainly functions in the removal of foreign material, but fat has not been demonstrated in the r-e cells when it is normally ingested or when it is injected as normal chylomicrons. Furthermore, blockade of the r-e system does not delay the removal of chylomicrons as such. The role of the liver, however, needs further evaluation. Chylomicrons do come into direct contact with liver cells as the liver sinusoidal walls have many gaps which allow the passage of large particles. However, the liver has no lipase, and liver function is normal in the great majority of patients with increased serum lipid levels.

One final bit of clinical evidence should be mentioned. Patients with nephrosis and essential hyperlipemia have markedly elevated serum triglycerides and have no known defect in reticulo-endothelial or liver function. However, an interference, of one type or another, with the heparin lipemia clearing factor does exist. Thus, in man the clinical and laboratory evidence available to date indicates that the heparin lipoprotein lipase machanism has the central role in the clearing of alimentary lipemia from the bloodstream, functioning in this regard much like insulin does in relation to carbohydrates.

REFERENCES

1. Hahn, P. F.: Abolishment of Alimentary Lipemia Following Injection of Heparin, Science 98:19, 1943.
2. Graham, D. M. et al.: Blood Lipids and Human Atherosclerosis, Circulation 4:666, 1951.
3. Engelberg, H.: Human Endogenous Lipemia Clearing Factor (active factor), Am. J. Physiol. 181:309, 1955.
4. Korn, E. D.: Properties of Cleaning Factor Obtained from Rat Heart Acetone Powder, Science 120:399, 1954.
5. Engelberg, H.: Heparin Lipemia Clearing Reaction and Fat Transport in Man, Am. J. Clin. Nutrition 8:21, 1961.

Eye Complications

Resulting from Systemic Medication*

Richard A. Perritt, M.D., *Chicago*

We have all been perplexed at some time by the patient who still has symptoms referable to his eyes even though a comprehensive examination has not revealed the cause. It is at this stage that I retrace my steps and start with a careful evaluation of every facet of the patient's history — that of his family, of his general health, and of all the regular or intermittent medication he takes.

While this article is not intended to include every possible eye condition produced by systemic medication, a few are common enough to warrant emphasis.

Belladonna and its alkaloids in spastic colon have induced glaucoma in susceptible individuals, and every physician should be alerted to this possibility. Artane and caramiphen, efficacious in the symptomatic treatment of parkinsonism, in some patients cause blurred vision, mydriasis, headaches, dizziness, epigastric distress, and nausea.

Large doses of the barbiturates (Amytal®, veronal, dial, evipal, pentobarbital sodium, phenobarbital, and Seconal®) produce dilatation of cerebral blood vessels and increase permeability of the capillary bed. One massive dose or relatively large amounts taken over a long period may produce the toxic symptoms[1] of ptosis, extraocular palsies, nystagmus, and transitory loss of vision.

Ephedrine and benzedrine (used in upper respiratory infections) cause such toxic effects as blurring of vision and dilated pupils. Bromides are used frequently and constitute a part of many patent medicines used for nervous disorders. They are absorbed rapidly and excreted slowly. They replace the chlorides in the blood, consequently a high salt intake reduces the likelihood of bromide poisoning. Eye symptoms include blurred vision, dilated pupils, and headache. Hanes advises blood bromide determination in every individual with a neuropsychiatric tendency.[2]

Color vision may be affected by commonly prescribed medication. Patients receiving santonin or extract of male fern to combat intestinal worms, may notice xanthopsia (yellow vision); and the optic discs may show pallor. The digitalized patient may see everything green, blue, or yellow; or strangely, he sees things white, as though covered with snow. In addition, floating spots may be apparent.

Quinine, used in the treatment of malaria or leg cramps, (15 grains to 1 ounce) can induce toxic amblyopia in the susceptible individual. The earliest finding is haziness of the disc margins and constriction of retinal arteries. The vision returns finally.

Diplopia can arise without any actual paralysis of the eye muscle and the reverse is true — i.e., partial or complete paralysis of an ocular muscle does not always produce double images. Even intelligent individuals do not always recognize double images; they simply complain of fuzzy or dazzling vision. The condition also can arise from cardiovascular dizziness, intracranial aneurysm, injury, neoplasm, abscess, syphilis, diabetes, hyperthyroidism, meningitis, exogenous poisons, lesions of the sinuses, myasthenia gravis, spinal puncture, encephalogram, and cranial exploration. Metamarphopsia is not always due to macular changes; partial calcarine lesions, cerebellar disturbances, and disease of the labyrinth can produce alterations in the shape of the objects seen.

Cobra venom, to relieve pain from diverse causes, increases visual acuity and widens visual fields for red and green, as reported by Macht.[3] Chloromycetin, effective against many infections

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caused by rickettsial organisms, certain viruses, gram negative bacteria, and gram positive organisms, is excreted mainly by the kidneys. Besides aplastic anemia, optic neuritis has been reported by Lasky.[4]

N. P. 207, a drug similar to Thorazine®, may lead to blurring of vision to 20/200 in two to three weeks, dilated retinal vessels, pink optic discs, and concentric contraction of fields.[5] Ring scotomas have been found. Dilantin®, used as an anticonvulsant, may produce diplopia, nystagmus, bilateral ptosis, and visual hallucinations. D.D.T., has produced optic neuritis. Herpes zoster ophthalmicus has ben observed as a result of arsenic therapy. Prolonged use of the sulfonamides and the salicylates can induce a tendency toward retinal hemorrhage.

Furadantin® and Urecholin® may lead to severe itching, burning, and tearing of the eyes. Even after medication is withdrawn, these symptoms continue for weeks and need adjunctive steroid therapy. Stramonium (jimson weed), used in cigarettes for asthma, may cause bilateral central scotoma. Streptomycin and dihydrostreptomycin may lead to hearing loss and optic neuritis.

Sulfonamide therapy may cause scaling of the eyelids, conjunctivitis, transient myopia, transient loss of accommodation, edema of retina, or optic neuritis. Tridione®, used for epilepsy, may produce sensitivity to light, extreme glare, or black on white colors. The chart may be read easily with dark glasses, but vision is 20/200 without them.

According to Gabinus, of 19 patients at the Jonkoping General Hospital who received 250 mg. of chloroquine daily for the treatment of rheumatoid arthritis and other collagen diseases, 8 showed epithelial and subepithelial deposits on the lower half of the cornea.[6]

REFERENCES

1. Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics. 2nd ed. New York, Macmillan, 1955. Pp. 209-15.
2. Hanes, F. M.: Chronic Bromide Intoxication. Oxford Medicine, 4:55-56 and 664. New York, Oxford Univ. Press, 1940.
3. Macht, D. I.: Therapeutics or Cobra Venom, Tr. Am. Therapeutics Soc. 40:62-69, 1940.
4. Lasky, M. A. et al.: Bilateral Optic Neuritis following Chloramphenicol Therapy, J.A.M.A. 151:1403-4, 1953.
5. Goar, E.: Visual Impairment from NP 207, Am. J. Ophth. 40:753-4, 1955.
6. Gabinus, O. et al.: Corneal Opacities from Chloroquine, Svenska Lak.-sallsk. forhandl., July 10, 1959.

More "free rides?"

There can be no dispute concerning the national need for new hospitals. Conflict of view on what form they should take and what function they should serve may provoke original thought and avoid perpetuating unfortunate and costly errors. It would be flippant to suggest that the Government should build expensive hotels in which hundreds of thousands of citizens could live expensively but free (in so far as anything paid for by taxes is free) for such varying times as they or their doctors considered their health was below par. Unfortunately, however, there is real danger that many of the millions pledged for hospital construction may provide hotels instead — and very expensive ones! The name "St. Trinian's Hospital" rather than "Hotel Sans Souci" in neon lights over the palatial entrance to a modern skyscraper will not alter the use made of its beds. *J. A. Stallworthy. Hotels or Hospitals? Lancet. Jan. 9, 1960*

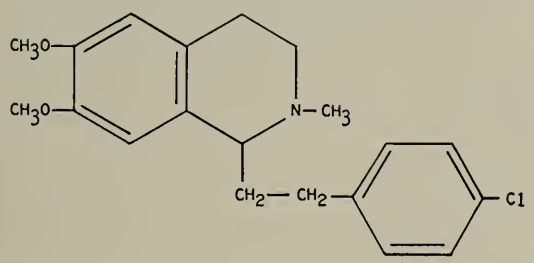
The cauldron's bubble

Data indicate that in certain family constellations, food giving and taking is a neurotic form of acting out. Since eating in our culture takes a social form, it is used as a kind of communication among those people who highly value oral pleasures. We can get a clue to the ambivalent qualities of this behavior in the stereotype of the woman whose kitchen behavior dominates the entire household. At the same time that she seemingly voluntarily slaves over a hot stove, she enslaves those dependent upon her by using her labors, in what she alleges as their behalf, as a badge of unrewarded martyrdom. There is not too subtle seasoning of guilt with the food she serves, to the end that a temporary peace can be had only if the members of the family passively surrender to eating what they may not want or may not need. *Howard P. Rome, M.D. Obesity: Psychiatric Aspects. Staff Meetings of the Mayo Clinic. March 16, 1960.*

Preliminary Clinical Report on A New Analgesic

Max S. Sadove, M.D., Syed M. Ali, M.D., and M. J. Schiffrin, Ph.D.*

One of the goals of chemical research is the development of a potent analgesic that is free of addiction liability. A compound, designated Ro 4-1778/1, which was recently synthesized and described by Brossi, et. al.[1], may have this property. Deneau and Seevers[2], department of pharmacology, University of Michigan, Ann Arbor, who studied the effects of Ro 4-1778/1 on abstinence signs of monkeys addicted to morphine and withdrawn from this narcotic, estimated the physical dependence capacity of the experimental drug to be "very low." Chemically the compound is 1(p-chlorophenethyl)-2-methyl-6,7-dimethoxy-1,2,3,4-tetrahydroisoquinoline and thus belongs to a new chemical group of analgesics. The structural formula of Ro 4-1778/1 is shown below:



The purpose of this study was to obtain clinical data which would provide an estimate of the potency of this drug when given orally. Codeine and placebo medication were used for comparison in a double-blind, controlled fashion.

Procedures

The 40 subjects included in the study were patients on the postsurgical orthopedic wards. They were selected for this investigation if their pain was sufficiently severe to warrant the use of at least 30 mg. codeine. Pain and sedation were evaluated and recorded before drug administration and 30, 60, 90, 120, and 180 minutes afterward. Pain and sedation were graded as 3—severe, 2—moderate, 1—slight, and zero—none. The "analgesic "score" was determined as subtracting the pain score at each observation period from that preceding the administration of the drug. The "total analgesic score" was the sum of these analgesic scores.

The doses used were 30 mg. codeine, 20 mg. Ro 4-1778/1, and 40 mg. Ro 4-1778/1. The placebos were 10 mg. tablets of synthetic vitamin E. The order of administration was randomized. Each dose was placed in an opaque, sealed envelope and numbered according to its sequence in the randomization. In this way there was no opportunity for the observer to learn the code since every dose was given a different number.

Distribution of drug administration among the 40 patients is shown in Table 1. The total numbers of doses of 30 mg. codeine, 20 mg. Ro 4-1778/1, 40 mg. Ro 4-1778/1, and placebo tab-

TABLE 1. — Distribution of Drug Administration

Drug	No. of Patients	Number of Doses			
		Codeine 30 mg.	Ro 4-1778/1 20 mg.	Ro 4-1778/1 40 mg.	Placebo
Codeine	7	7			
Codeine and 20 mg. Ro 4-1778/1	2	2	6		
Codeine and 40 mg. Ro 4-1778/1	2	2		2	
Codeine and placebo	2	2			2
Codeine and 20 and 40 mg. Ro 4-1778/1	7	11	11	10	
20 mg. Ro 4-1778/1	2		2		
20 and 40 mg. Ro 4-1778/1	3		5	3	
20 mg. Ro 4-1778/1 and placebo	1		1		1
40 mg. Ro 4-1778/1	8			8	
Placebo	6				7
Totals	40	24	25	23	10

*Division of Anesthesiology, University of Illinois College of Medicine, Chicago

Ro 4-1778/1 was supplied by courtesy of Hoffmann-La Roche Inc. of Nutley, N. J.

lets were, in this sequence, 24, 25, 23, and 10. The total numbers of patients who received one or more doses of these medications either alone or alternating with one or two of the other materials were 20 for codeine, 15 for 20 mg. Ro 4-1778/1, 20 for 40 mg. Ro 4-1778/1, and 9 for placebo tablets. If these patients are considered as four groups, there were no significant differences among the groups with respect to age, disease, type of surgery, and number of days since surgery.

Results

All patients had a premedication pain score of at least 2, and the averages of the initial scores for the four groups ranged from 2.2 to 2.6 (moderate to severe pain). The differences among these averages were not significant statistically. Average analgesic scores for all doses are shown in Table 2. It is apparent from these

TABLE 2. — Average Analgesic Scores

Drug	No. of Doses	30′	60′	90′	120′	180′	Total
Placebo	10	0	0.3	0.3	0.3	0.2	1.1
Codeine, 30 mg.	24	0.3	0.8	1.1*	1.3*	1.2*	4.7*
Ro 4-1778/1, 20 mg.	25	0.1	0.6	1.1*	1.4*	1.3*	4.5*
Ro 4-1778/1, 40 mg.	23	0.1	0.9	1.3*	1.4*	1.3*	5.0*

*Significantly larger than placebo, $P<0.01$ (student t test).

data that, beginning with the 90-minute estimation, all drugs provided a significantly greater analgesic effect than the placebo. The order of increasing effectiveness of the active materials was 20 mg. Ro 4-1778/1, 30 mg. codeine, and 40 mg. Ro 4-1778/1. A statistical analysis of the analgesic scores, comparing the effects of the two doses of Ro 4-1778/1 and of codeine, showed that differences in degree of pain relief were not significant.

Data relating to analgesia were analyzed in two other ways. Any patient whose analgesic score was at least one for at least four periods of pain scoring was arbitrarily considered to have derived "adequate pain relief." A summary of the analysis of these data is shown in Table 3. None of the patients who received the placebo had adequate pain relief. The order of increasing effectiveness of the analgesic drugs was 20 mg. Ro 4-1778/1, 30 mg. codeine, and 40 mg. Ro 4-1778/1.

TABLE 3. — Percent of Doses Providing Adequate Pain Relief. (Analgesic score of one or more for at least 4 periods of pain scoring)

Drug	% With Adequate Relief
Placebo	0
Codeine, 30 mg.	67
Ro 4-1778/1, 20 mg.	56
Ro 4-1778/1, 40 mg.	70

Further, data pertaining to patients who received more than one of the active drugs were analyzed so that comparisons of drug effectiveness within the same patients could be made. Data summarizing such a comparison are shown in Table 4. It is again apparent that the order of increasing effectiveness of the three analgesic doses was 20 mg. Ro 4-1778/1, 30 mg. codeine, and 40 mg. Ro 4-1778/1.

There were no statistically significant differences among these three doses. However, we consider it significant that their order of effectiveness remained the same in all three methods of analysis. On this basis it is suggested that the potency of Ro 4-1778/1, when given orally, is of the same order of magnitude as that of codeine.

TABLE 4. — Average Total Analgesic Scores in Patients Receiving More Than One Drug

Comparisons	No. of Patients	No. of Doses	Total
Codeine vs. Ro 4-1778/1			
Codeine, 30 mg.	9	13	4.8
Ro 4-1778/1, 20 mg.	9	17	4.1
Codeine vs. Ro 4-1778/1			
Codeine, 30 mg.	9	13	4.4
Ro 4-1778/1, 40 mg.	9	12	4.7
Ro 4-1778/1 Dosage			
Ro 4-1778/1, 20 mg.	10	16	3.8
Ro 4-1778/1, 40 mg.	10	13	4.8

Sedation was not a significant effect of drug administration, and the differences between the degree of sedation produced by the analgesic drugs and placebo were not significant statistically. There were no instances of nausea or emesis. The only adverse reaction noted was headache in one patient who received 30 mg. codeine.

Summary

1. The effectiveness of 20 and 40 mg. doses of a new analgesic, Ro 4-1778/1, 30 mg. codeine, and of placebo medication, all given orally in a double-blind fashion, was studied in 40 postoperative patients on the orthopedic service.

A total of 82 doses of analgesics and placebo were given.

2. The degree of analgesia produced by 20 or 40 mg. Ro 4-1778/1 and by 30 mg. codeine was significantly greater than that produced by placebo medication.

3. The order of increasing analgesic effectiveness, based on three different methods of analysis, was 20 mg. Ro 4-1778/1, 30 mg. codeine and 40 mg. Ro 4-1778/1. It is suggested that the analgesic effectiveness of Ro 4-1778/1 and of codeine, milligram for milligram, is of the same order when these drugs are given orally.

REFERENCES

1. Brossi, A., Besendorf, H., Pellmont, B., Walter, M., and Schnider, O.: Halogensubstituierte 1-Phenäthyl-2-methyl-6,7-dimethoxy-1,2,3,4,-tetrahydro-isochinoline als Analgetica, accepted for publication in Helv. Chim. Acta.
2. Deneau, G. A., and Seevers, M. H.: Personal communication.

More on steroids

The challenge intrinsic in steroid administration, the potential benefit versus possible adverse effect, is acceptable. It should not deter the proper usage of these drugs in a crippling disease. Despite the foregoing drawbacks, steroids, used with due caution and watchful attention, have a definite place as a drug supplement in rheumatoid arthritis. Their beneficial effects may greatly facilitate patient care when additional therapeutic efforts are concretely indicated. Until more effective and safer agents are discovered, their use in selected cases seems warranted.

The clinician, however, should not be lulled into a false sense of security. It is important for him to remember that whenever corticosteroids are employed in rheumatoid arthritis, whatever product or dose is selected, he is doing little more than suppressing some manifestations of a disease which may be progressing in spite of symptomatic improvement. Steroids cannot prevent all joint damage, nor can they be expected to return a damaged joint to normal. They are a part, not the whole, of comprehensive management in rheumatoid arthritis. *Dwight C. Ensign, M.D., John W. Sigler, M.D., and G. M. Wilson, Jr., M.D. Steroids in Rheumatoid Arthritis. AMA Archives of Internal Med. December 1959.*

Remission but no cure

Remission treatment has become almost a standard practice for acute leukaemia, because it offers a high expectation of clinical improvement and the risks of toxicity with modern methods are small. Since remissions alone, and never cures, have been obtainable by use of the present antileukaemic drugs, a more fundamental form of treatment is needed urgently. One possibility follows upon the animal work of Medawar (1958) on homografts with tissue cells, following which grafts of foetal haemopoietic tissue after total body x-irradiation have been tried (Thomas et. al., 1959). The hope of ultimate success from this or other methods gives a further measure of justification for the interim use of the agents capable of inducing remissions. *Reginald Lightwood, M.D., et al. Observations on 100 Cases of Leukaemia in Childhood. Brit. Med. J. March 12, 1960.*

To the infantryman, his country's military might is only those buddies he can see, and the equipment they have at hand; likewise, to the wage-earner, "free enterprise" is primarily the way his boss treats him and those around him.

— Malcom Forbes

MEDICAL ECONOMICS



Relative Value Studies

W. C. Bornemeier, M.D., *Chicago*

For many years the medical profession has recognized the need for a rule-of-thumb measurement that could be used to help remove public criticism of medical fees.

Medical services vary — one appendectomy is not like another appendectomy any more than one sack of potatoes is like another. The farmer or merchant gets more for one sack of potatoes than he does for another; he gets a different price in different areas for the same potatoes. Yet some people feel that all appendectomies should be the same price.

At any rate, there is enough difference of opinion to justify flexible fee schedules. The patient and the third party payer prefer fixed fee schedules. The physician prefers to vary his charges according to the value he places on the individual service. Even so, physicians' charges are fairly standard. We know, however, there are isolated instances of charges that are apparently quite out of line and stand out like sore thumbs.

Purpose of studies

To correct the "out of line" fees and to justify those that may seem out of line, the Relative Value Scale was devised after a three or four year study begun in California.

The Scale in no way sets anyone's fees or schedule of fees, and it does not tie all physicians and specialists, such as surgeons, radiologists, pathologists, into one firm schedule regardless of skill, competence, training and reputation. It can be used by the physician as a basis for establishing his fee schedule.

Basically, relative value studies attempt to evaluate by a unit or point designation, the time, competence, effort, experience, and other factors required to perform one professional service compared to those required for other professional services.

How values are set

There are three parts to the relative value study: the service, the point value, and the coefficient. The first thing a physician does is list all possible services involved in the care of any patient. Then he rearranges these services in a progressive order with those requiring the least skill, time, and overhead preceding those requiring the most skill, time, and overhead. It will be seen at once that this job is impossible unless we first separate the services into subsections of surgery, general medicine, radiology, and pathology. Part of the reason for the division into subsections is that overhead must be considered; therefore, radiology and pathology, with large outlays for equipment, must be separated from surgery and medicine. Again, surgery and radiology usually cost in multiples of 5 and 10, while pathology and medicine cost in multiples of 1 and 2. That means that no two of the four classifications can be considered in the same category, therefore four categories.

From here on it is simple. Take any category and arrange the services. Give the one costing the most time, effort, and overhead the highest point rating and then move down by a relative reduction. Or start at the bottom and work up by in-

creasing the point value. For example, surgical services might be arranged thus:

Drainage of abscess, superficial	1.0
Drainage of infected bursa	3.0
Excision biopsy of breast	10.0
Closed reduction of fracture clavicle	10.0
Bronchoscopy, diagnostic	15.0
V-excision of large lesion of lip	15.0
Anal fistulectomy	20.0
Repair of rectocoele	25.0
Repair of perineum and third degree laceration of rectum	30.0
Exploratory laparotomy	35.0
Calculus of bladder — crush and remove	40.0
Excision of lesion of iris of eye	50.0
Cholecystectomy	55.0
Radical mastoidectomy	60.0
Subtotal gastrectomy	70.0
Gastrectomy	100.0
Total colectomy	100.0
Pancreatectomy, Whipple	100.0
Aortic anastomosis	100.0

A similar scale listing all procedures can be prepared for medicine, radiology, and pathology.

Studies, or Scales of Relative Value have been prepared and approved by many state societies. To make charges uniform — if the physician wishes to have his charges uniform and in line with his colleagues — the county or area must agree on a coefficient. In the partial schedule above, copied from the California Relative Value Study, the coefficient could be 5. In larger cities, it might be 6. Multiply the point value by the coefficient to get the dollar value. Thus, anal fistulectomy with a point value of 20 in a county using 5 as a coefficient, would be worth $100.

A physician, who by reason of reputation, location, or desire to get a higher fee than is average in his area, could set his own coefficient. He would use the same coefficient for all his procedures, employing the value scale to indicate the relative value of the procedures.

"Fringe" benefits

Such Relative Value Scales, in states which have adopted them, make it easy for insurance companies, if they are to pay in full, to know about what or exactly what the fee should be in the area. It also permits a patient to know what the cost will be if he goes to a physician or surgeon who is following the schedule and using the coefficient selected in his area. Naturally, additional procedures call for additional fees, all according to the schedule.

The Relative Value Scale also permits a union or prepayment group paying 75 per cent of the charges to use the scale and apply a coefficient of 3.75 in an area where the coefficient is ordinarily 5. Thus each patient would pay one fourth of the charges out of his own pocket and the fund would pay the balance. A welfare agency might agree to a coefficient of 3, the physician charging the balance to charity.

Also avoided is the patient's suspicion that fees are raised if he is insured.

The Illinois State Medical Society has studied this entire problem, but has not reached any conclusions concerning the need for it in the state. Since more and more states are adopting Relative Value Scales it is well to know a little about how they are set up and how they function.

April Council Meeting

The regular meeting of the Council was held at the Hotel Sherman, Chicago, on Sunday, April 24, with the following present: O'Neill, Hesseltine, Hamm, Burdick, Lull, Clark, Redmond, Adams, Reichert, Portes, Piszczek, Dooley, Blair, Endres, Reisch, DuPuy, Goodyear, English, Montgomery, Fullerton, Klein, Oldfield, Hamilton, Compton, Limarzi, Bornemeier, Sondag, Bettag, Fowler, Neal, Oblinger, Mirt, and Frances Zimmer.

The minutes of the March 13, 1960, meeting were approved as mailed.

Report of the President

Dr. O'Neill reported that he had attended the meeting with the Illinois Hospital Association. He also attended a meeting of the Committee on Annual Meeting Programming where a feeling of enthusiasm indicated we may look forward to a very fine annual meeting.

The Governor has asked that the Illinois State Medical Society again co-sponsor "Mental Health Week." As president, Dr. O'Neill was asked to attend the dinner May 2, at the Hilton Hotel in Chicago.

Dr. O'Neill stated that he had very carefully gone over the minutes of the special called meeting of the House of Delegates as printed in the Illinois Medical Journal. Because of certain references in the minutes, together with letters from various parts of the state relative to "the Council usurping prerogatives of the House of Delegates," and the request for interpretation of actions taken by the Council, he asked that each Councilor be familiar with the minutes of the House of Delegates and ready to discuss and define Council action relative to the care of people over 65 years of age.

At the December meeting the Council was instructed to report definitely upon those things in the Edlund report that the Council had taken upon itself to handle. In May there should be re-definition of actions and functions of the House, and of the functions of the Council. Council members should go to reference committee meetings well informed about what actions were taken and why. Each Councilor should be able to discuss anything directed to him and/or to the Council as a whole.

At the last meeting of the Council a reprint of the postgraduate program in Michigan was distributed, and members were asked to consider such a program for Illinois. If this matter is not handled by the present Council, it will be fall before work gets underway.

Motion: (Hesseltine-Reisch) that the chairman of the Council appoint a new committee to look into the present status of postgraduate medical education in Illinois. (Motion carried.)

There are approximately 2,000 physicians in the state who are not members of organized medicine. Some of these physicians should be encouraged to join, and this impetus should develop at the county society level.

Discussion of the situation in regard to nonmembers followed. Dr. Hamilton called the attention of the Council to the fact that many

of these physicians are not yet citizens of the United States, and are therefore, ineligible for membership. Dr. Endres reported that employees of state hospitals who were full citizens might be interested if some special dues structure could be developed for them; the same is true of full-time teachers. Dr. Lull stated that many other medical societies have a special dues structure for full-time employees, and that this might be considered by our House of Delegates.

MS and PR

Dr. Hamilton reported as chairman of the Committee on Medical Service and Public Relations. The full working force of the committee has been beamed against the Forand Bill. The "timing" of our activity in the coming weeks is most important. The consensus is that this being an election year, some type of legislation will be passed, and due to the political situation, with no regard as to whether the legislation is right or wrong.

Mr. Neil, Mr. Oblinger and Mr. Scott have talked before various groups such as luncheon clubs and American Legion groups. Councilors should take upon themselves additional responsibility along this line.

Mr. Oblinger reported success in some of the political campaigns throughout the state and the appreciation expressed by the candidates.

Dr. Hamilton paid tribute to the concentrated efforts of Mr. Oblinger, Mr. Neal, Mr. Scott, and Mr. Mirt.

Dr. Hesseltine, president elect, stated that there had been less activity since the March meeting of the Council. Attention was called to the meeting in Washington, D.C., planned by the Chamber of Commerce, and that the Society had been asked to lend its support.

Report of the Secretary

Dr. Lull reported that the Executive Committee recommended that Mr. White of Pennsylvania, a prospective employee secured through Conley Associates Inc., be asked to come to the annual meeting so Councilors may meet him.

According to the Finance Committee, the budget for 1960-1961 will be developed as soon as the figures are available from the auditor, who started the annual audit a week ago.

The Finance Committee made the following recommendations.

1. That a Chicago auditing firm be employed in the future. New vouchers are being printed, and a more accurate record can be kept for tax purposes.

2. That the officers, AMA delegates, and certain employees be sent to the AMA annual meetings, and to the interim meetings.

3. That the society accounts in the National Bank of Monmouth and the State Bank and Trust Company of Evanston be closed, and that accounts be established in the Continental Bank, where our retirement plan is established.

4. That all new and present employees have a yearly chest x-ray and that new employees be given a pre-employment physical examination at the expense of the Society.

Motion: (English-Piszczek) so move. (Motion carried.)

Dr. Reisch reported that the study of the Journal advertising was underway and a report would be made at a later time.

Dr. English suggested that the auditing firm employed by the AMA might be considered for future work.

Motion: (English-Reisch) that the same auditing firm employed by the AMA be considered by the ISMS. (Motion carried.)

Motion: (Piszczek-Portes) that the man being considered for Medical Service and Economic Research (Mr. White of Pennsylvania) be asked to attend the annual meeting. (Motion carried.)

Dr. Endres asked that information be distributed to all members of the Council dealing with the setup of the Society, and that this information should be available also for all county medical society membership.

(Executive Administrator, Public Relations Director and Field Services, Scientific Publications, Medical Service and Economic Research cover the four fields in which men have either been employed or are being considered for employment.)

Dr. English discussed the cost of Society participation in AMA meetings — travel for officers, delegates and alternate delegates, and certain employees, plus the expense of Society headquarters during the meetings. He stressed the feeling that perhaps the interm session does not justify this expenditure.

Dr. English asked that a cost sheet be developed dealing with the expense of the ISMS to

attend this meeting, and that perhaps this Society could present a suggestion to the AMA House of Delegates that clinical sessions might be abolished.

Motion: (English-Portes) that the expenses of the selected personnel be approved for the June meeting of AMA. (Motion carried.)

Motion: (Piszczek-Oldfield) that the Continental Illinois Bank be approved for the accounts of the ISMS. (Motion carried.)

Motion: (English-Piszczek) that Dr. Reisch, as chairman of the Journal Committee, be asked to report at a later meeting. (Motion carried.)

Expenses for coming year

Dr. Montgomery pointed out that the present year would be one in which heavy expenses could be anticipated — equipment, furniture. new personnel, etc. — and stressed the importance of all members of the Council being well versed in what is going on in the reorganization of the Society.

He felt that the employment of Richards and the other men will produce the answers to a lot of the criticism leveled at the headquarters' office, and that the Society can and will develop in service and efficiency. Each member of the Council should be versed in the background for all actions taken, since much of the criticism results from the fact that many physicians do not understand the functions of the House, the Council, and the employees.

It was Dr. Montgomery's opinion that the actions taken were within the dues structure. Since this was the last meeting of the Council prior to the annual meeting, he also stressed the importance of being familiar with the minutes of the December meeting of the House, as well as with Council activity.

Fact sheet for Councilors

Discussion followed. Dr. Portes asked that a fact sheet be developed for all members of the Council showing income, expenditure, etc., under the old setup as well as an outline of proposed expenses, overhead, etc. for the coming year.

Motion: (Goodyear-Clark) that such information be developed and sent to each member of the Council. (Motion carried.)

(This fact sheet should show past records, anticipated dues under the new dues structure, former salary totals, rent totals, and also the rent and salary structure as it will exist after the opening of the coming fiscal year.)

Over-65 study

A general outline of Council action relative to the care of people in the over-65 group was given; the fact that individual participation in the proposed coverage was available at the county level was stressed. Dr. O'Neill told of the three letters mailed to all members, the careful consideration given the committee reports by the Council, and the serious problem of "timing" which existed throughout. He called the attention of the Council to one remark made at the December meeting, "that the Council made no report to the House," and felt such utter lack of knowledge about the affairs of the Society was almost impossible to correct. Dr. Redmond stated that any physician not wishing to participate in the program had the privilege of not signing up, or if he has signed, he has the privilege of withdrawing his name at any time.

Relative value study

Dr. Reisch called the attention of the Council to the fact that the House had asked for a relative value study, and to his knowledge such a report had not yet been presented.

IPAC

Dr. Compton reported as chairman of the Advisory Committee to the Illinois Public Aid Commission, and stated that the state-wide letter relative to rulings on drugs and prescriptions resulted in some difficulties and a good many comments. The main fact to keep in mind is that programs such as the IPAC are regulated and controlled by law. A few physicians had issued prescriptions in the unapproved manner, and the mailing was to correct this situation.

Dr. Portes stated that many of the county meetings dealing with the White House Conference on Aging were being held under the auspices of the local county IPAC setup, that all physicians should attend, and that county societies should be alerted as a result of mailings dealing with these meetings.

Constitution and By-Laws

Dr. Bornemeier outlined the proposed changes for the Constitution and By-Laws to be presented

to the House as requested at the special session in December including suggestions from the Council as a result of the Edlund report.

Motion: (English-Goodyear) that the term "executive secretary" be changed "executive administrator." (Motion carried.)

Motion: (O'Neill-Goodyear) that the president elect be included with the president and the chairman of the Council to appoint reference committees for the House. (Motion carried.)

Motion: (English-Portes) that the report of the Constitution and By-Laws Committee be approved with the changes suggested by the Council. (Motion carried.)

Postgraduate education

Dr. Limarzi, chairman of the Committee on Postgraduate Medical Education and Scientific Service, reported that the last of this year's meetings is scheduled for LaSalle on April 28, with the Chicago Medical School presenting the program. The Mattoon meeting was held on April 7 with Stritch School of Medicine of Loyola University giving the scientific program. The work of the Scientific Service department goes along well. The committee will be most pleased to cooperate in any new thinking or programming for postgraduate education in Illinois.

Nutrition Conference

Dr. Lull presented a letter from Paul A. Dailey, chairman of the Committee on Nutrition. The committee requests permission of the Council to co-sponsor the Annual Conference on Nutrition with the Illinois (state) Nutrition Committee again in 1960. This meeting would be held the first Friday and Saturday in October at Normal State Teachers' College in Normal. The two previous conferences sponsored jointly with the Committee have been well attended and have resulted in good public relations for the Society.

Motion: (DuPuy-Hamm) that the request be granted. (Motion carried.)

New office

Dr. Lull stated that the work in the Chicago office is progressing; the new furniture will be delivered soon, and the office will be moving from 185 N. Wabash to 360 N. Michigan on Monday night, April 25.

Medical Assistants

Dr. Carl Clark reported that the Medical Assistants Association is planning its next convention for some time in the near future. The group is not financially independent, and due to the wage scale of its members, probably never will be. Therefore, the Advisory Committee requested that the Council consider giving them $300 as they have in the past to assist them in holding their meeting.

Motion: (Portes-English) that the $300 be authorized. (Motion carried.)

Public health

Dr. Sondag, assistant director of the Department of Public Health, reported. A national health survey is being conducted under the auspices of the Department of Vital Statistics of the USPHS to establish body build, height, weight, etc. at the national level. No information will be given out; no particular income group is to be involved. They plan to do physical examinations of a selected group of the population, a total of 6,000 in the United States, from 42 stations, two of which are to be located in Chicago. The first of these examination periods is set for September: 150 in September on the north side of the city, and 150 later on from the south side. The examination is extensive but not comprehensive. It is to be restricted to measurements; no personal opinions are to be expressed; no pelvic examinations are to be made. Hearing is to be tested, EKG's taken, height, weight, urine, blood cholesterol. Persons will be selected as the result of a survey to be conducted carefully by trained personnel. Trailers will be set up for the work, and a copy of the findings will be sent to the family physician of any individual so requesting. The work will take about two hours, will be done by third-year residents in internal medicine in Chicago. A "dry run" will be conducted so that there will be no slip-up in technique or in procedure.

Auxiliary committee on aging

Dr. Portes asked that the Council recommend to the Advisory Committee to the Woman's Auxiliary that the county auxiliaries appoint a "Committee on Aging" to assist at the local level and to work with the Society in this important field. Dr. Redmond, as chairman, stated that the

Auxiliary is doing work along this line, and he would bring up the matter of committee appointments at a meeting to be held soon.

Dr. Lull reported that a letter of interest to all had been received giving a general outline and report of the Illinois Medical Service. At the suggestions of the Council it is to be mimeographed and attached to these minutes.

Motion: (English-Piszczek) that the chairman of the Council appoint representatives from the Illinois State Medical Society to the Interprofessional Council. (Motion carried.)

Note: Dr. Montgomery reported that the following would so represent the ISMS: E. A. Piszczek, Chairman, Chicago; A. J. Brislen, Chicago; and George Callahan, Waukegan.

Resolution for the House

Dr. Lull reported receipt of a letter from Dr. Lafe Ludwig, chairman of the AMA Council on Medical Service, extending appreciation for the contributions made to Council committees by Dr. W. L. Crawford of Rockford, as a member of the Committee on Maternal and Child Care, and by Dr. Dean W. Roberts as member of the Committee on Indigent Care. It was Dr. Ludwig's opinion that the services of these men should receive recognition from their own society House of Delegates and/or their society Council.

Motion: (Reichert-English) that resolutions be prepared and presented to the House of Delegates. (Motion carried.)

Public Welfare

Dr. Bettag reported that he had received a host of replies from the legislators in Washington relative to the action taken by his department as a result of a request from Mr. Oblinger. Dr. Bettag had reported in detail the extensive work of his department in the field of rehabilitation and care for the aged. Mr. Oblinger told of the fine program going on all over Illinois under the Department of Public Welfare, and stressed the importance of informing people of the efforts expended by the state in behalf of this age group.

Dr. Bettag discussed the possibility of a permanent home for the ISMS and also the CMS in the West Side Medical Center and called attention of the Council to the fact that land is still available as well as a building which might represent an economically sound investment.

Investment funds for M.D.'s

Dr. Endres stated that he felt the Society should appoint a committee to study opportunities for investment of deductable income if and when the Mather-Keogh Bill (HB #10) might be enacted into law; it would pertain to the self-employed, and provide that a certain amount of income could be exempt from taxation until such time as it is withdrawn from any structural investment program. While the individual might not have more than $2,500 to invest annually under such a program, the physicians of Illinois represent a potential of some $23,000,000. If only half of them were interested in a mutual investment program, it would involve $11,000,000 annually, and perhaps the 7½ to 8% loading charge could be lowered under such a program.

Motion: (Endres-English) that the chairman of the Council appoint such a committee to study an investment program available for the "self-employed" if and when HB #10 is enacted.

The motion was amended to provide for the expenses of such a study. (Amendment carried.) (Motion carried.)

Dr. English suggested that the matter be referred to the Finance Committee and that information would be available from the AMA's investment counsel and from the Continental Bank, and such information should be made available to the House. The Finance Committee should so consult, and be ready to recommend plans. Dr. Lull called the attention of the Council to the fact that any number of sources were available for information and that no fee would be involved until participation in the plan was begun.

Fee schedule

Dr. Lull discussed a letter received from the American College of Radiology relative to a fee schedule used by the Division of Vocational Rehabilitation of the State of Illinois. This fee schedule resulted from use of the setup developed by the Veterans Administration under its program for care of the veteran with service-connected disabilities at home by the physician of his choice. In about 1949 it was decided that the Division of Vocational Rehabilitation would utilize the same fee schedule. Dr. Bettag discussed this procedure, and stated that his department would be glad to cooperate on any revision or future activity in this field.

Motion: (English-Portes) that this file be referred to the Committee on Medical Service. (Motion carried.)

Section status

Dr. Lull presented a letter from Dr. Edward E. Gordon of Michael Reese Hospital, asking that section status be given the specialty of Physical Medicine and Rehabilitation. Discussion followed, and the fact was presented that under the Constitution and By-Laws it is the responsibility of either the Council or the House to establish the various sections.

Motion: (O'Neill-English) that this matter be referred to the Committee on Annual Meeting Programming for a recommendation on which to base future action. (Motion carried.)

Dr. Reisch to Washington

Dr. Fowler told of the meeting planned by the National Chamber of Commerce in Washington. Dr. Hoeltgen and Dr. Fowler will attend, and a physician from downstate Illinois should also be present.

Motion: (Hesseltine-English) that the chairman of the Council appoint a representative to go to Washington, D. C., for the Chamber of Commerce meeting. (Motion carried.)

Dr. Montgomery requested Dr. Jacob E. Reisch of Springfield represent the Society.

Dr. Endres called the attention of the Council to the legislative actions taken from time to time by the American Nurses Association, and felt that anyone knowing any of the state or local officers in this group should contact them and discuss problems with them in detail.

Dr. Lull presented an insurance problem faced by one of the downstate physicians and asked for consideration.

Motion: (Piszczek-Fullerton) that the file be referred to the Committee on Prepayment Plans and Organizations. (Motion carried.)

Motion: (Piszczek-Fullerton) that the list of Emeritus and Retired members be elected as listed.

EMERITUS

Mitchell, James H.	Chicago	CMS
Molander, Charles O.	Chicago	CMS
Schmechel, Alfred R.	Chicago	CMS

RETIRED

Alexander, Berthold	Arizona	CMS
Artz, George E.	Cicero	CMS
Haney, Irl S.	Elmhurst	CMS
Jenkinson, E. L.	Wisconsin	CMS
Jurek, L. J.	Chicago	CMS
Lanman, E. L.	Belleville	St. Clair
Leon, H. G.	California	CMS
McCullough, J. D.	Aurora	Kane
Sherman, Irene C.	Oak Park	CMS
Strikol, Michael T.	Chicago	CMS
Tillson, Wm. D.	LaGrange Park	CMS
White, Clifford Paul	Chicago	CMS

Motion: (Piszczek-Fullerton) that the bills as audited by the Finance Committee be approved. (Motion carried.)

Dr. O'Neill on PG work

The chairman of the Council appointed Dr. Joseph T. O'Neill as the chairman of a committee to investigate postgraduate education in Illinois.

Other business

Dr. Reisch asked for action assuring a report to the House of Delegates dealing with relative value studies, and Dr. Hesseltine was asked to revise the report he submitted following the Indianapolis meeting dealing with the problem.

Dr. Montgomery requested the chairmen of all committees to send Dr. Lull a report of attendance at committee meetings during the past fiscal year.

The Council adjourned following the luncheon.

Respectfully submitted,
George F. Lull, M.D.
Secretary

BLUE SHIELD Medical-Surgical Plan of Illinois
Medical Service
425 North Michigan Avenue, Chicago 90, Illinois

April 13, 1960

Dr. George F. Lull, M. D., Secretary
Illinois State Medical Society
185 North Wabash Avenue
Chicago, Illinois

Dear Dr. Lull:

With growing nation-wide concern about health care and its costs coupled with proposed legislative programs drawing considerable public attention, the activities of voluntary medical care plans become increasingly important. As a result, I am sure you will find this brief

summary of the status and progress of the Illinois Medical Service for 1959 of interest. In accordance with the instructions of our Board of Trustees, I am pleased to present the following report.

Membership in our Plan continued to increase during 1959, and by the end of the year totaled 2,141,920 members. This represents an addition of 166,691 members over December 31, 1958.

Benefits paid and provided for in allowances towards physicians' fees in 1959 for services rendered to our members amounted to $19,841,276, as compared to $17,788,452 paid in 1958. A total of 465 physicians' reports of services to members were processed during the year.

During 1959 assets decreased by $188,267 from a December 31, 1958, total of $13,352,459 to a 1959 year end total of $13,164,192.

The reserve for future Medical Care increased in 1959 to $7,876,740. This represents an addition to the reserve of $34,292 from December 31, 1958, and is computed after provisions are made for all known and estimated unreported cases still to be paid.

Again in 1959 a Non-Group Enrollment Campaign was conducted to provide membership opportunity to individuals who would otherwise be unable to enroll. Approximately 24,000 people took advantage of this enrollment offer to obtain protection against future medical bills.

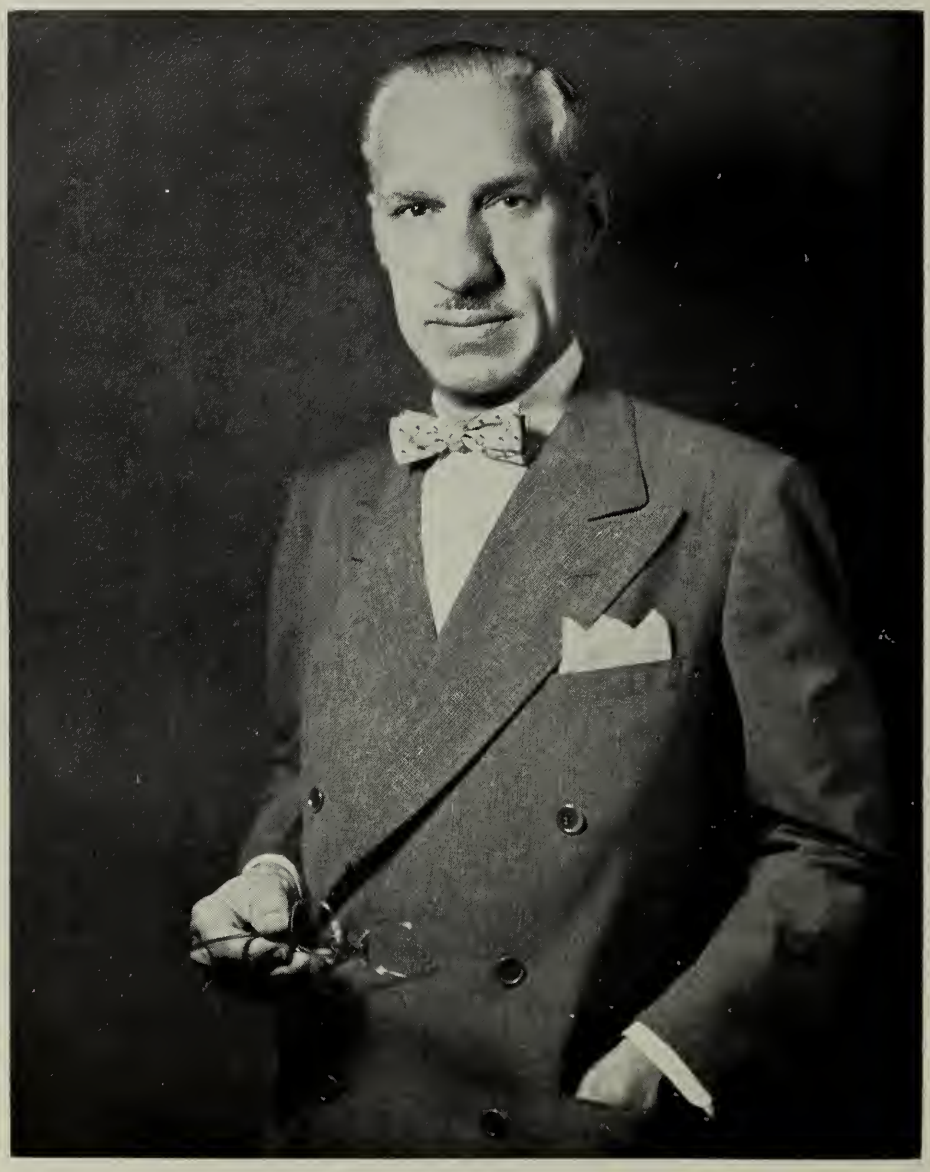
Highlights of the year 1959 included our two millionth member celebration when membership reached that total with the enrollment of an employee of the Jewel Tea Company. As noted above, our membership has continued to increase since that time. Another important event during the year was the decision to install a modern electronic computer. Long range planning and activity in preparation for the eventual installation in 1961 continues on schedule.

In today's constantly changing world of medical practice and economics, we are indeed fortunate to have the direction of a realistic and progressive Board of Trustees, supported by the whole-hearted interest from medical organizations such as yours. Thus, we have been able to develop the efficiency and economics so vital to the operation of this Blue Shield Plan and, at the same time, to grow in membership and provide better service to our members.

May I take this oportunity on behalf of the Illinois Medical Service and its members to express our appreciation to the Illinois State Medical Society and its membership for their cooperation and encouragement during 1959. With such support I'm sure our Plan and the vital service it provides will continue its growth during 1960.

Sincerely,
R. T. Evans (signed)
Executive Director





H. Close Hesseltine, M.D.

President, Illinois State Medical Society

1960-1961

ISMS Meeting Briefs

Dr. Hesseltine new ISMS president

Dr. H. Close Hesseltine, Mary Campau Ryerson professor of obstetrics and gynecology of the University of Chicago School of Medicine, became president of the Illinois State Medical Society at installation ceremonies of the annual meeting May 26. He succeeds Dr. Joseph T. O'Neill of Ottawa.

Dr. Hesseltin brings to the office the broad viewpoint of a practitioner in medicine, full-time professor, and research worker, and an understanding of problems of the Society.

He has long been a tireless worker in the ISMS having served in various capacities on numerous committees and as chairman of the Council from 1956 to 1958. He has shown much interest in prepaid medical care and was instrumental in setting up the retirement program for employees.

Dr. Hesseltine is a graduate of the University of Iowa College of Medicine, Iowa City, 1925, took his internship and residency in obstetrics and gynecology at University Hospital there, and remained to teach. He came to Illinois in 1931 to teach at the University of Chicago. In addition to his professorship, he is attending obstetrician and gynecologist at Chicago Lying-In Hospital. He has published many papers in national medical journals on infections peculiar to women.

He has been active in the Chicago Medical Society and is a past president of the Chicago Gynecological Society and is a trustee and director of the Illinois Medical Service. In the AMA he is presently consultant to the Committee on Prepaid Medical Insurance of the Council on Medical Service and member of the joint committee of the AMA-AHA on Medico-Legal Education Review, and a past-chairman of the AMA Committee on Health of Women in Industry. In addition to memberships in the many national societies of his specialty, he is a member of the American Association for the Advancement of Science, Society of American Bacteriologists, Society of Experimental Biology and Medicine, an alumnus member of the AOA, University of Iowa, and belongs to the Central Travel Club and the Quandrangle Club of Chicago.

Dr. Hamilton chosen president elect

Edwin S. Hamilton, M.D., of Kankakee, a leader in international medicine as well as in civic and business affairs in his community, is the new president elect of the Illinois State Medical Society.

Other elections were:

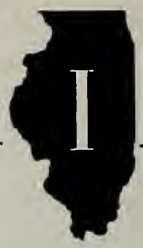
Drs. Andrew J. Brislen, Chicago; first vice president; Clinton D. Swickard, Charleston, second vice president; Jacob E. Reisch, Springfield, secretary-treasurer; J. Ernest Breed and Theodore LeBoy of Chicago, Burtis E. Montgomery of Harrisburg, Willard W. Fullerton of Sparta and Newton DuPuy of Quincy, councilors; Maurice M. Hoeltgen, Leo P. A. Sweeney, and Carl F. Steinhoff of Chicago, Harry Mantz of Alton, and Dr. Montgomery, delegates to the American Medical Association; H. Close Hesseltine and Norris J. Heckel of Chicago, Raleigh C. Oldfield of Oak Park, and Paul A. Dailey of Carrollton, and Lester S. Reavley of Sterling, alternate delegates.

Dr. Hamilton is one of the founding members of the World Medical Association and a member of its board of trustees. He has traveled internationally for the WMA. He also is a former chairman of the board of trustees of the American Medical Association; served on the Illinois State Medical Society Council for 27 years, the longest term of any; and is president of the Kankakee County Medical Society.

He holds an A.B. degree from the University of Illinois, S.B. degree from the University of Chicago, and M.D. degree from the Rush Medical College of Chicago. He interned in the Cook County Hospital, Chicago. During World War I he served overseas with the St. Luke's Hospital unit with the rank of a captain in the medical corps.

In Kankakee he is president of the Kiwanis Club, director of the Chamber of Commerce, vice president of the City National Bank, president of the Kankakee County Title and Trust Company, and member of the Kankakee County Country Club, Masons, Shrine, Elks, and American Legion. He also is a member of the Chicago Athletic Association.

From the Secretary's Office



One of the interesting events of our move: A desk drawer would not close, and investigation brought to light a number of envelopes from down under the back of the drawer. One was a letter with a P.O. money order for $3.00 for an ad insertion in the Journal. Date of letter and M.O., November 14, 1944.

Be sure to see that your county medical society is represented when the county meetings on the White House Conference on Aging are held. As dates become known in this office, your county society is notified.

Sometime ago, our president, Joseph T. O'Neill, sent a letter to each county medical society in the state urging them to attend the Harold M. Camp Memorial Lecture on Wednesday, May 25, during the annual meeting.

We have had many calls from physicians relative to the "Honest Ballot Association" of New York City. We have inquired about this organization, and find that it is an old, established one. However, the survey of Illinois physicians is being made by them at the request of the Physicians Committee for Social Security, which is an offshoot of the Physicians Forum. At no time was the Illinois State Medical Society consulted relative to this survey, the membership list being obtained from some mailing organization.

Posters for hospital bulletin boards have been mailed to chiefs of staff of all Illinois hospitals. Four of these posters were sent with a request that one each should be turned over to the administrator and chiefs of medicine and surgery. Have you seen them? If not, inquire.

Most of the remaining degree mills in Illinois are religious in nature. They include the American Bible School, which gives degrees in Theology, the College of Universal Truth, Kondora Theosophical Seminary, and Pioneer Theological Seminary. One institution is a law school (Blackstone) that was organized "to meet the demand for law trained men." According to an HEW release: "Letter to prospective students states regarding entrance requirements: 'You don't need a college education, in order to study law! You don't need high school either! You don't even need grammar school! Law is a study that stands by itself. . . .' "

The 1959 report of the Scientific Director of the Tobacco Industry Research Committee has been received. It is a very interesting report and includes abstracts of papers that have appeared in scientific journals 1958 through July 1959. The address is 150 E. 42nd., New York 17.

On September 13, 14 and 15 the Fourth National Cancer Conference will be held in Minneapolis, Minn. This Conference is held at four year intervals and is jointly sponsored by The American Cancer Society and the National Cancer Institute. The theme will be "Changing Concepts Concerning Cancer." and the program will be an outstanding one.

George F. Lull, M.D.
Secretary

EDITORIALS

Mr. Richards New ISMS executive administrator

The Illinois State Medical Society this month welcomes Mr. Robert L. Richards as executive administrator. He joins the Society after having served as executive director of the American Society of Internal Medicine in San Francisco.

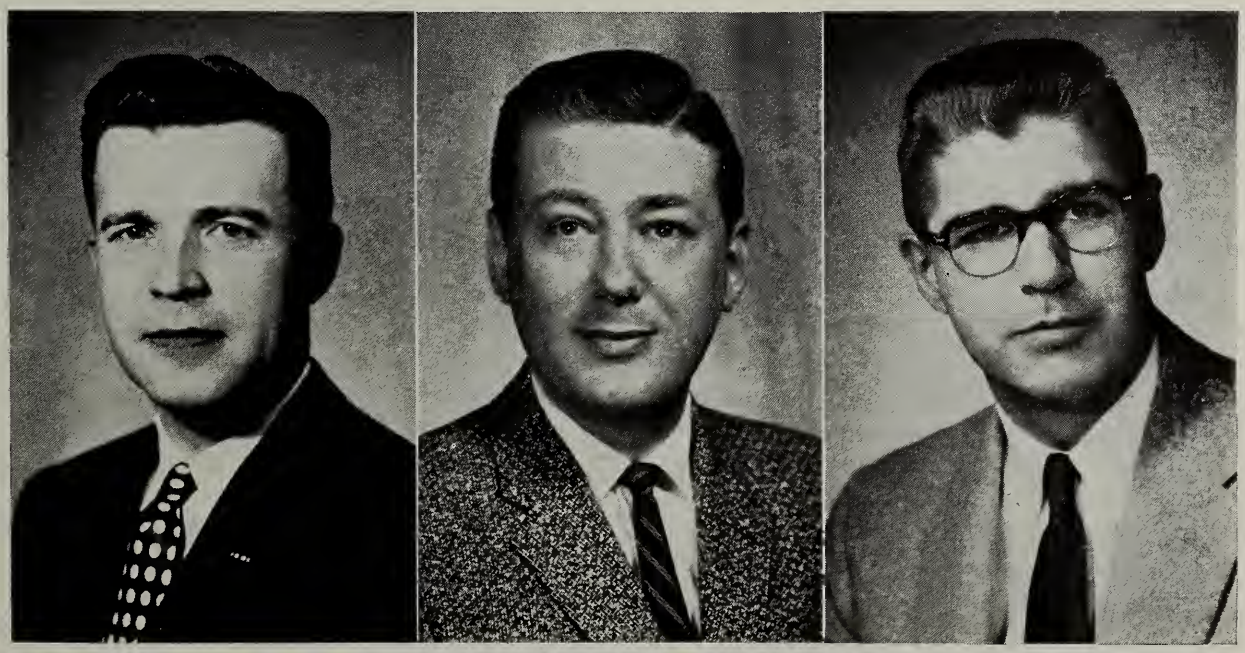
Mr. Richards is well trained in this field. He was with the Medical Society of the State of Pennsylvania for eleven years as staff secretary to the committees of the society, director of public relations and coordination of the committees, and finally as assistant director. In this capacity he directed staff activities in public relations, legislation, socio-economic and scientific areas, and served as administrative assistant to the executive director.

A native of Pennsylvania, Mr. Richards received his A.B. degree from Gettysburg College, where he specialized in history and education, and he has done graduate work at the American University in Biarritz, France.

In World War II he served as a line Company Commander and as a regimental personnel officer with United States Paratroopers in the European Theater. He was awarded the Silver Star for gallantry in action and the Purple Heart. In 1946 he was separated from the service as captain.

Mr. Richards is a member of the Medical Society Executives Association, The American Public Health Association, the Public Relation Society of America, The American and California Societies of Association Executives; and the Press Club, Union League Club, and Kiwanis Club in San Francisco. Earlier he served a year a president of the Kiwanis Club in Harrisburg, Pa. He has addressed many meetings and convention groups.

While many in the Society undoubtedly had an opportunity to talk with Mr. Richards at the annual meeting last month, we are happy that he is now an official member of the family.



Robert L. Richards Donald L. Martin Al Boeck, Jr.

Mr. Martin to direct ISMS public relations

Effective July 1, Mr. Donald L. Martin, Springfield, director of information for the Illinois State Bar Association, will become director of public relations for ISMS in Chicago.

Mr. Martin has been with the bar association since 1951 as executive assistant, assistant secretary and then managing editor of the Illinois Bar Association Journal. Since July 1955 he has served in his present position directing the association's public information and publications programs that have twice won top national awards from the American Bar Association.

Son and grandson of physicians, Dr. Delmar I. of Springfield and Dr. George Martin of St. Elmo and Brownstown, Mr. Martin is a graduate of Springfield Junior College and St. Louis University, where he majored in pre-medicine.

He is a veteran of three and one-half years in the U. S. Naval Reserve and served overseas as pharmacist's mate second class at the end of World War II.

In Springfield civic affairs he has been publicity director for the 1959 United Fund Campaign and is presently publicity director for the second YMCA building fund campaign. He is on the board of directors of the Springfield Advertising and Public Relations Club and has served on both the public relations and publications committees of the American Society of Association Executives.

Mr. Martin has been selected as a finalist nominee for Outstanding Young Man of 1959.

He, his wife Helen Ann, and their two children—Barbara, 15, and Mike, 13—will make their home in Wheaton.

Mr. Boeck, scientific activities and publications director

Mr. Al Boeck, Jr., assumed duties May 17 as director of scientific activities and publications of ISMS. He comes to Chicago from Madison, Wis., where he has been assistant to the vice president of advertising and public relations of the Oscar Mayer Co. During his four years there he helped establish a corporate public relations program and developed product publicity, wrote speeches, news releases, and features.

He had previously been engaged in public relations work for the Upstate Medical Center of the State University of New York at Syracuse, where he established their publications program, operated the news bureau, and served as an administrative aide in production of college publications and professional programs. The printing service he designed and supervised has become the model for the state university system.

Mr. Boeck did his undergraduate work in his native state, Iowa, at Simpson College in two years with honors in history. Under a graduate fellowship at Indiana University he earned his M.A. in journalism and did further graduate work at the State University of Iowa under an internship in its Information Office while completing his M.A. degree in public relations. He has also been working on his Ph.D. in mass communications at Syracuse University.

Mr. Boeck has been a director of public relations and instructor in English and journalism at State Teachers College in River Falls, Wis., where he established their first public relations program, and he held a like position at the State University Teachers College in Onenta, N. Y.

His extra-mural activities in Madison have included serving as public relations chairman of the Dane County Mental Health Association and Jaycee projects, Chamber of Commerce Promotion Committee, and various PTA and Press Club activities.

He is married and has two sons.

Task completed

With sincere regret we relinquish the strong guidance of Dr. George F. Lull this month who has served the Society since October 1959 as secretary-treasurer. We were extremly fortunate in obtaining the services of a man who had just resigned after a long period of administrative service at the AMA: secretary and general manager from January 1946-58 and assistant to the president during 1958. Before going to the AMA he had retired from the Army as Deputy Surgeon General with the rank of Surgeon-General.

We realize that Dr. Lull's tenure of duty has been beset with the many problems of reorganization of the Society, including selection of new offices and moving.

Those who have worked with Dr. Lull are impressed with the practicality of his voice of experience, with his sincerity and understanding

and his knowing and able advice. We thank him for his help over a difficult period. With him to his new fields of endeavor go our best good wishes.

The viral etiology of leukemia

The past decade has seen a remarkable renaissance of interest in the etiology of leukemia. This has become highlighted by the work of several groups of investigators. Gross induced leukemia in a low leukemic strain of mice by inoculation of newborn animals with cell free extracts of leukemic tissues; Graffi obtained similar results using extracts of malignant mouse tumors; Kaliss demonstrated that tumor tissue was leukemogenic even after lyophilization; Magrassi and Mas y Magro produced a diffuse guinea pig disease by the use of tissue extracts of human leukemia; Bergol'ts induced leukemia in mice with extracts of leukemic human tissues; Charlotte Friend induced leukemia in adult mice by a cell free filtrate; Sarah Stewart was able to propagate an agent in tissue culture which produces multiple tumors when inoculated into newborn mice. More recently, viruses have been demonstrated in human leukemia by means of the electron microscope by Dmochowski, and several investigators have shown that a virus is involved in roentgen induced leukemia of mice.

Our own investigations on the etiology of human leukemia have taken a somewhat different direction. The a priori assumptions on which the experiments were based were (1) that leukemia is a systemic infectious disease; (2) that the "leukemic" manifestations of the disease represented a defensive host response, and (3) that the causative agent would probably be found in its least modified form in those tissues in which histologic evidences of leukemia were minimal. For these reasons we have used cell-free filtrates and cell-free supernates of brain as the inducing material instead of tumor or leukemic tissue, and in both the experimental model, using the mouse, and the crucial experiments, using material from human sources, brain extracts have been found to have high leukemogenic activity. Based on the findings to date, a number of conclusions may be drawn:

1. Leukemia may be transmitted to both leukemia susceptible and nonsusceptible adult mice by the use of cell-free filtrates obtained from both leukemic mouse and leukemic human brain.
2. Both active and passive immunity may be induced in the mouse, and active immunization seems possible in man.
3. An inhibiting substance is present in leukemic tissues which interfers with the demonstration of the leukemogenic agent.

These experiments do not conclusively prove that viruses are directly etiologically responsible for leukemia. Even the demonstration of viruses in leukemic tissues will not prove this. However, the evidence is becoming formidable that a cause and effect relationship, even if indirect, exists. When this becomes established, a signal forward step toward the understanding of leukemia will have been taken.

Steven O. Swartz, M.D.

Fractured hips

In 1935 Dr. Kellogg Speed[1] called the fractured hip "the unsolved fracture." Each of three major schools of thought in the development of treatment has favored a different type of treatment. The first and formerly predominant group was conservative in its preference of a plaster of Paris spica; indeed, it was the only form of treatment in the early days. The body spica gave satisfactory union of bone in from 50 to 90 per cent of cases; however, the high of 90 per cent was never borne out in my experience. The method entails confinement in bed for at least three or four months. Since ankle, knee, and hip remain stiff after removal of the cast, to mobilize them often required more time and care than that necessary for healing the fractured hip. And the mortality was high, particulary among the elderly, for whom prolonged bed rest, even when changing positions, is a hazard. Furthermore, contractures occurred in the joints; muscles became fibrotic.

Traction was the next common type of immobilization practiced. This permitted the patient to sit up in bed and to move the ankle and foot, but it did not immobilize the knee; thus it caused contractures and stiffness in the knee joint. The outlook with traction was a little better than 50 percent union of bone. The incidence of bone growth was low; this left much to be desired regarding healing of the fractured site.

Closed internal fixation followed as the third

method of treatment and results were better. The advent of effective lateral view roentgenograms of the hip joint gave it impetus. Methods of internal fixation employed wires, screws, and flanges in the form of a Smith-Petersen nail, the variations having been made possible by Smith-Peterson[2], who revised the use of metal in the neck of the femur. Moreover, by roentgenographic control, especially through the help of anteroposterior and lateral views, anatomic reduction became more nearly accurate. Closed internal fixation could be accomplished under local anesthesia with little shock to the patient. Early mobilization was possible, although union of bone still varied from 75 to 90 per cent. At the same time introduction of mechanical aids — guides and special apparatus — allowed the patient to assist himself.

Today many still believe that closed internal fixation is the best form of treatment; others believe that, notwithstanding correct reduction and anatomic position, union of bone fails in a certain percentage of cases because of soft tissue interposition at the time of the accident. It should be borne in mind that a person does not fall and break his hip; he breaks his hip and then falls. This sequence has prognostic significance, because of the danger at the time of the accident that soft tissue will be impacted or driven between the bone ends that have been separated by the external rotation. Furthermore, internally rotating and correcting the position and then securing it by means of some form of internal fixation does not accomplish union so often as an open operation does.

An open operation exposes the fractured site, permits freshening of the surfaces, and provides opportunity to secure correct position by some form of internal fixation. Of additional importance is the opportunity afforded the surgeon to see how much circulation is present before he proceeds. Aged patients with fractures of the hip often do not have any circulation in the head of the femur, and operative procedure must be governed accordingly. On the whole, open internal fixation gives better results and a lower mortality than any other method.

A current trend is to remove the fractured head of the femur and immediately insert a metal prosthesis. Resins and plastics had been tried, but they cracked or broke and had to be removed. Most surgeons agree that for those patients past life expectancy, for those who have a malignancy, or for those who have had an old coxa magna or some related pathologic disorder metal prostheses are contraindicated. When they are used judiciously, however, results have been encouraging.

Subtrochanteric osteotomy is another currently popular form of treatment, the techniques for which vary. The purpose is to change the weight bearing so there is a direct weight to the head. The aim is to increase circulation and remove the stress angle. Some surgeons combine osteotomy with internal fixation. Osteotomy alone or in combination with internal fixation is recommended here to secure a union of bone.

Advances are being made to ascertain the status of the circulation. By the use of tagged materials one can determine fairly well the amount of circulation in the head of the femur. This investigative channel is still superficially explored but promises to minimize the number of unwarranted surgical procedures.

Notwithstanding significant improvements in techniques of treatment, because no one yet knows what makes bone grow, a fractured hip in 1960 remains the "unsolved fracture" of 25 years ago.

James J. Callahan, M.D.

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1. Speed, Kellogg: Surg. Gynec. & Obst. 1935, 60:345.
2. Smith-Petersen, M. N.: Surg. Gynec. & Obst. 1937, 64:293.

Label warnings for drugs

The pilot of the airlines that crashed near Charlottesville last October was taking tranquilizer pills, according to a UP story that appeared in local newspapers. He had been under the care of two psychiatrists, as though one were not enough.

No mention was made of the type of tranquilizer, or whether one or both psychiatrists had forbidden him to fly. The pilot may have been depressed because of a recent divorce and loss of custody of his children. A tranquilizer under these circumstances was indicated.

The basic question is whether a pilot should be grounded while undergoing psychiatric care or while taking certain drugs. If the physician is of this opinion, he should insist even to the point of calling the employer. The life of his patient and others are endangered by any other approach.

Many modern drugs have an adverse effect on vision, equilibrium, judgment, concentration, and

other faculties used in everyday living. We will never know how many seemingly goofy, reckless, or inattentive drivers have just left a psychiatrist's office or taken their medicine. A warning is in order when potentially dangerous drugs are prescribed. The least we can do is insert on the prescription "Do not drive or operate machinery while taking this medication."

T. R. Van Dellen, M.D.

Fad feeding

Most medical conventions are covered by the press and releases are made well in advance by the public relations department. The program is scanned for "newsy" items that will catch the public eye. Some of the authors are aware of what editors want and include choice tidbits that mean very little but make headlines and publicity.

Science writers are looking also for something new and different. A recent release on a revolutionary infant feeding program was a natural for their papers. It stemmed from a talk given by a Miami pediatrician at the twelfth annual assembly of the American Academy of General Practice. These were the results of his recommendations relative to feeding 1,500 infants.

The pediatrician "pointed out that even babies in hospital nursery do nicely on a six hour feeding schedule and enjoy cereal when they are only two or three days old." Oatmeal and barley are the best starters, preferably as thick as putty. Strained vegetables are added to the noontime feeding at ten days; four days later he adds strained meats at noon or at 6 p.m.

By the seventeenth day the child is eating regular little meals. This is followed by orange juice and cod liver oil, and on the fourth week they get soft-scrambled, coddled eggs or hard boiled egg yolk. Crisp bacon, well crumbed, is added by the ninth week.

He "added that the six month old child often enjoys and is not harmed by an occassional cup of coffee."

There is a good chance that your patients will read this before you do unless you attended the convention.

We are so anxious to have our children grow up; and after they do, we are sorry that they are no longer children. Mothers may be enthusiastic about these accelerated programs, but they are missing one of the most enjoyable periods of life by concentrating on solid foods instead of nursing.

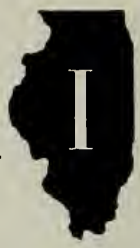
The study made headlines, but demonstrates only one thing: Infants can tolerate almost any type of food with the possible exception of fats.

T. R. Van Dellen, M.D.

Military service for physicians

Selective service informs us that the Armed Forces needs most physicians liable for military service under the Universal Military Training and Service Act. All reserve officers deferred for residency in most specialties will be called. Shortages exist in certain specialties and in the group of officers who have not specialized. In addition, there is a continuing need for applications for the residency program as well as for reserve commissions and active duty at the conclusion of internship.

AT THE EDITOR'S DESK



Subminiature Hearing Aid

Telex, Inc. makes a new hearing aid in which the ear receiver is not directly connected to the eyeglasses which house the transmitter. This permits the wearer to remove his glasses without detaching or removing the earpiece. They have been able to eliminate the mechanical connection by making the glasses a subminature radio transmitter and the earpiece a receiver. The tiny transmitter broadcasts with a power of one one-thousandth of a watt over a distance of less than half an inch. Electronics are wonderful — we expect a device any moment that will let us know what others are thinking about. Deafness will no longer be a handicap because we will be able to communicate via thought waves. The ears will become a vestigial, women will no longer be mysterious, and blushing will become a major problem.

Pharmaceuticals

You pays your money and takes your choice. There were two news releases on the treatment of obesity by competing companies with appetite-suppressing drugs to sell. Writers for Wm. S. Merrill stressed three reasons why 36 million Americans are overweight: habit, heredity, and unhappiness. The writers for Nordson tackled the problem by giving three reasons why most fat people do not lose weight: One in three really doesn't want to, one in five is too dumb, and one in five has to overeat for emotional satisfaction.

Sorboquel is reported by White Laboratories to be a new highly effective anti-diarrheal drug for the symptomatic treatment of both acute and chronic diarrheas. So far so good, but the news release continues, "that will be made available in the near future." We wonder how many lay diarrheators can wait until the product comes on the market.

MER-29, the highly publicized anticholesteremic agent of the Wm. S. Merrell Company, was made available for prescription use June 1.

Regardless of the cause, both had the solution. Merrill recommended their new drug Tenuate, whereas Nordson suggested Levonor. Needless to say, diet was mentioned by both but relegated to a somewhat inferior position.

"Methakote," a new pediatric creme for the treatment and prevention of diaper rash, cradle cap, excoriations, and chafing of the infant skin, has been announced by the Pharmaceutical Division of the Borden Company.

Orabase Emollient (Squibb) is a special dental protective paste that will stick to the wet surfaces of the mouth and gums for prolonged periods. It is reported to be of value in the treatment of any injury to the oral tissues resulting from denture irritation, toothbrush trauma, or cancer sores.

New simplified tests for ketone bodies in urine, blood, serum, milk, and other body fluids were described recently by a group from the Ames Research Laboratory. They are especially useful in children and in diabetics receiving oral hypoglycemic agents. Ketostix is the name of the newcomer. It reacts with acetoacetic acid in contrast to Acetest that reacts with both acetoacetic acid and acetone.

Seize Health Cocktails

Many physicians will be happy to read the April Report on Enforcement and Compliance of the FDA, in which the Honey-Vinegar "Health Cocktail" was seized. Honey and apple cider vinegar will not keep the doctor away even though a best-selling book advocates the combination as the secret of perfect health and long life, according to the Food and Drug Administration. More than 5,000 cases of the mixture were seized on charges that it was misbranded because the label failed to bear "adequate directions for use" in the many disease conditions for which it was intended. Directions for use cannot be "adequate," FDA said, if the product will not be effective when the directions are followed.

Those writing on a rival product called fibrinolysin (plasmin) appear to be more optimistic than our local clinicians. Deep-lying leg veins obstructed by clots improved faster and suffered fewer complications, according to Dr. Kenneth Moser of our nation's capital. He came to these conclusions following a controlled study of 62 patients. Fibrinolysin has been given to laboratory animals soon after an experimentally produced heart attack. It seemed to flush away a sludge of microscopic clots in the smallest coronary vessels, and according to Heart Research News letter, it reduced by as much as 25 to 50 per cent the damage to the heart muscle.

We may see the day that an enzyme will be able to clear out a coronary or carotid artery or to dissolve a clot in a saphenous vein. But more time needed to evaluate our present products.

Artificial Kidneys, Coffee Dispensers, Etc.

Articles on health and medical progress are given high priority by editors of newspapers, magazines, TV, and radio. A story on the artificial heart or kidney makes headlines because we have been raised on the idea that man cannot improve on nature. Such inventions are ingenious and are regarded as the epitome of scientific progress.

But our medical machines are toys compared with modern computors, such as the Univac, that do more work in an hour than an army of men can do in a year. A computor is limited only by the capacity of the men who decide what they want the machine to do and the men who know how to make the proper adjustments so that it will perform properly. Hence, it is not "a brain" even though it makes calculations more rapidly than is possible by a mathematical genius.

The peripatetic correspondents of the *Lancet* also consider the artificial heart a simple contrivance compared with the most primitive American coffee dispenser. The heart pump, according to the correspondent, has only to pump a few pints of blood; but a coffee dispenser must know whether the individual wants black coffee, coffee with cream, coffee with sugar, or coffee with sugar and cream. It must know how much coffee to put into each cup, and the same applies to the quantity of sugar and cream.

We are as awed as this Britisher who said, "Have you ever wondered how the cup always arrives first, then the coffee, then the cream, and lastly the sugar, and always in that order?"

He also praised the soft drink dispenser that distinguished between American and English coins. Coke machines and coffee dispensers have one advantage over the artificial heart and kidney. They refuse to work when empty even though primed with a genuine dime. When the heart or lung machine fails—you've had it.

New Test for LE

A simple diagnostic test for disseminated lupus erythematosus has been devised at the National Institutes of Health. It is so accurate and quick that it can be used for screening purposes. The diagnostic procedure is similar to that originally used to identify rheumatoid arthritis. The new test employs desoxyribonucleic acid (DNA) rather than gamma globulin to coat and sensitize bentonite, a type of colloidal clay. When a drop of patient's serum is added to this mixture, a flocculation occurs in a few moments if the disease is present.

Drugs Produced as a Service

Many specialty drugs are used so seldom that they are marketed at a loss. They are continued because of their value in the treatment of rare diseases. According to the publication, New Medical Materia, no reasonable price to the patient could cover the costs of research, development, clinical trials, quality controls, manufacturing, and distribution. They are donations "as a service to physicians and their patients."

Eli Lilly, for example, makes acetyl strophanthidin for critical cases of congestive heart failure. There were only 150 known cases in 1959 requiring this drug. They also produced colchicine ampules in that year for 75 cases of acute gout. Wyeth makes Direct Sky Blue for detecting cancerous tissue in surgery. It was used on less than a thousand cases. Ketonil® is a Merck product that was administered to prevent mental deterioration in an equal number of infants and children with phenylketonuria. Mead Johnson keeps a supply of Lofenalac® for the same purpose. Cutter has a rare human blood fraction for the maintenance of patients with hemophilia B. There were 5 or less cases in 1959.

The publication listed a sampling of 32 products in this category. The pharmaceutical industry deserves a vote of thanks for making these drugs available.

Plotting Vaccine Supply and Demand

This spring the surplus of polio vaccine stacked up to 26.4 million doses, while 90 million Americans still needed to be vaccinated. This is becoming a usual occurrence in the winter months as well, according to Dr. Leroy E. Burney, Surgeon General of the Public Health Service, and is likely to be followed by a shortage in the summer when an increase in polio reminds people they should be vaccinated. It takes four months to manufacture the polio vaccine. The material will be difficult to impossible to get if the demand is high this summer.

Dr. Burney suggests that we remind our patients that the vaccine is most effective if used before polio is prevalent and that it is the third shot, due seven or more months after the first two, that gives the greatest protection.

Lease X-ray Equipment

Cobalt teletherapy, x-ray apparatus, and fluoroscopic equipment can now be leased for terms of three years and longer from Nationwide Leasing Company of Chicago. The cobalt units include Theratron Junior, the Theratron "B," and the Eldorado Super C and all models of machines of Standard X-ray Company, which is cooperating in this venture.

Fumes and Fuming

Regarding automobiles: Publishers Printing Company quotes the Bureau of Public Roads as estimating 114 million cars by 1976. This represents a climb of 63 per cent over the 70 million of the past year. At this rate there will be three cars to every four drivers — a sales pitch for the small two-seaters because passengers will be scarce. The report also states that Detroit is worried about compulsive legislation relative to air pollution. Manufacturers are taking the initiative and providing devices to control crank-case fumes on all cars to be produced in 1961. What about exhaust fumes which are far worse than those from crank-cases?

Molecule Juggling

Roerig's ex-medical director made some interesting comments before Kefauver's committee this winter. Dr. H. J. Weinstein was opposed to molecule juggling by competing pharmaceutical firms because it resulted in a flood of me-too products — different enough to by-pass patents rights but too similar clinically to be worth the research cost and effort. The scores of tranquilizers, oral diuretics, and new cortisones are typical examples. The pharmaceutical industry came back with examples of how molecule juggling also produced improved products (oral penicillin) that benefited many patients.

Weinstein also objected to valueless drug combinations, such as steroid-tranquilizer mixtures, and berated the battle of additives that has been going on in this industry. These points are mentioned to acquaint physicians with pharmaceutical jargon and to explain why so few new products are really new. Each drug must be carefully evaluated from this angle. The extra premium the patient pays for a product with greater horsepower or faster absorbability may not be worth the difference. Combination drugs are not always needed, and all too often the active ingredients can be purchased alone at half the price.

Long-haired Brain Surgery

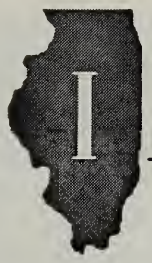
Williams, writing in the April issue of the Journal of the International College of Surgeons, recommends an ordinary, nonlacquer hair spray in lieu of shaving the scalp for brain surgery. He has his female patients wash their hair five times in the 3-5 days before surgery with a detergent-hexachloraphene shampoo. Following anesthesia, the hair is moistened, parted along the line of intended incision, and combed into small pony tails. The hair spray is applied two or three times over the entire head and the incision is made. The spray is antiseptic because of its high alcohol content.

The advantage: She leaves the hospital with unshorn locks.

Clearing the Arteries

The enzymes used to dissolve intravascular clots are difficult to purify. The strep organism, for example, produces in the neighborhood of 100 different substances along with streptokinase. Some of these can cause reactions in man. They believe at Lederle that the impossible has been accomplished: They now have a half ounce of pure streptokinase. It cost them $250,000. According to a company release, intense research is now underway to try to refine the production process so larger and more economical yields can be obtained.

ANNOUNCEMENTS



Committee on rehabilitation

A new Medical Advisory Committee in the Office of Vocational Rehabilitation has been established with Dr. Howard A. Rusk, director of the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, as chairman.

The committee will assist in the planning of long-range medical programs and policies related to the current and expanding State-Federal rehabilitation program. Dr. Dean W. Roberts, executive director of the National Society for Crippled Children and Adults, Chicago, is one of the 10 members of the committee.

July clinics for crippled children

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing service. There will be two special clinics for children with cardiac conditions, one for children with cerebral palsy, and one for children with rheumatic fever.

Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative service.

July 1—Chicago Heights (Cardiac), St. James Hospital
July 6—Hinsdale, Hinsdale Sanitarium
July 7—Flora, Clay County Hospital
July 12—East St. Louis, St. Mary's Hospital
July 12—Peoria, Children's Memorial
July 13—Champaign-Urbana, McKinley Hospital
July 13—Joliet, Silver Cross Hospital
July 14—Cairo, Public Health Building
July 14—Sterling, Community General Hospital
July 14—Springfield, St. John's Hospital
July 19—Alton, Alton Memorial Hospital
July 19—Danville, Lake View Hospital
July 19—Quincy, St. Mary's Hospital
July 20—Evergreen Park, Little Company of Mary Hospital
July 21—Elmhurst (Cardiac), Memorial Hospital of DuPage County
July 21—Rockford, St. Anthony's Hospital
July 26—Effingham (Rheumatic Fever), St. Anthony's Hospital
July 26—Peoria, Children's Hospital
July 27—Aurora, Copley Memorial Hospital
July 27—Springfield P.M. (Cerebral Palsy), Memorial Hospital
July 28—Decatur, Decatur-Macon County Hospital
July 28—Mt. Vernon, Masonic Temple

Malformations bibliography

Publication of a new monthly annotated bibliographical record of articles on congenital malformations published in periodicals throughout the world has been announced by The National Foundation. "Current Literature—Congenital Anomalies," the first comprehensive reference on the subject, will be sent initially to 1,700 selected individuals and institutions all over the world.

Free booklet on epilepsy

A new booklet, "Epilepsy—Its Causes, Effects and Treatment," designed to give the epileptic, his family and friends an understanding of the condition and advice about treatment, is available free of charge from the Federal Association for Epilepsy.

It was written especially for the association by Dr. Virginia A. Duggins, a member of the staff of the Department of Neurology and Neurological Surgery, George Washington University School of Medicine.

Copies may be obtained from the Association at 1729 F St., N.W., Washington, D.C.

NEWS of the STATE

County

Cook

Chicago Societies. At the May program of the Chicago Surgical Society papers presented were "Modification of the T Tube," Edwin M. Miller, (Discussants: John T. Reynolds, and Francis H. Straus); "Ulcerogenic Tumors of the Duodenum," Harry A. Oberhelman and Thomas S. Nelsen; "Gangrenous Perforation of the Gallbladder," E. Lee Strohl, Willis G. Diffenbaugh, J. H. Baker, and M. A. Cheema. The Society's Annual Award for Surgical Research was presented to Harry A. Kaupp, Jr. for his paper, "The Role of Cerebral Edema in Ischemic Cerebral Neuropathy Following Simulated Cardiac Arrest in Dogs and Monkeys and Its Treatment with Hypertonic Urea."

Lectures. The final lecture in the annual North Shore Hospital Lecture Series on Office Management of Emotional Disorders was given June 1. "Management of the Psychiatric Patient Not Suited to Office Practice," was discussed by Dr. Eugene S. Turrell, professor and chairman, department of psychiatry, Marquette University School of Medicine, Milwaukee.

Dr. T. R. Van Dellen, editor of the Illinois Medical Journal, spoke on "The Practicing Physician, Transmitter of Medical Information to the Public" in a symposium on Medical Communications Day, co-sponsored by the *New York State Journal of Medicine* and the American Medical Writers' Association New York Chapter, May 14.

Appointments. Dr. Samuel Andelman, Chicago's new commissioner of health, has been chosen president elect of the Illinois Association of Medical Health Officers.

Dr. John P. Waitkus, a member of the staff at St. Bernard's Hospital, has been named chairman of the department of surgery.

Fulton

Dr. K. H. Frankhauser, Avon, spoke on "Clinical Hypovitaminosis," at the May meeting of the Fulton County Medical Society.

Lake

"A New Amine Buffer for Clinical Acidosis" by Dr. S. J. Anderson and "The Mechanism of Action of New Diuretic Agents" by Dr. R. L. Herting were the topics of discussion at the May meeting of the Lake County Medical Society.

Madison

Dr. Ben H. Senturia, associate professor of clinical otolaryngology, Washington University School of Medicine, spoke on the subject, "Deafness: What Can Be Done About It?" at the May meeting of the Madison County Medical Society.

Sangamon

Meeting. The May meeting of the Sangamon county Tuberculosis Association celebrated its olas Hotel. Dr. Benjamin Boshes, chairman of the department of neurology and psychiatry at Northwestern University, spoke on the subject, "Current Relationship of Psychiatry to Medicine."

Fiftieth Anniversary. The Sangamon County Tuberculosis Association celebrated its 50th anniversary with a dinner at the St. Nicholas Hotel on May 11. Dr. David B. Radner, medical director of Winfield Hospital and director, chest department, Michael Reese Hospital, spoke on "The New Challenge in Tuberculosis."

Vermilion

At the April meeting of the Vermilion County Medical Society, the formation of a Health Council for the promotion of good public health and sanitation in the entire county was approved unanimously by the Society.



Sentinel Staff Photos

These ten Southern Illinois physicians posed with Gov. William G. Stratton represent well over 500 years of medical service to their communities. Left to right, Drs. Claude J. Sanders, H. D. Gillette and J. Carl Hall of Centralia; Dr. Andrew Hall of Mt. Vernon; Dr. H. L. Logan of Salem; Governor William G. Stratton; Dr. Roscoe Vernon of Nashville; Dr. William Parker of Mt. Vernon; Dr. James Wells of Waltonville; Dr. Beverly Moore of Benton and Dr. H. O. Williams of Centralia.

General

Fifty-Year Club Banquet. Three physicians were honored at a banquet at flower-decked St. Mary's Hospital in Centralia May 4 on having completed 50 years of practice. Members of the Marion County and the Jefferson-Hamilton medical societies and their wives attended.

A 50-year certificate and pin were presented to Dr. H. D. Gillette of Centralia by Dr. Arthur Goodyear of Decatur, ISMS Counsellor. Dr. Andrew Hall, Mt. Vernon, made the presentations to his nephew, Dr. J. Carl Hall of Centralia and to Dr. William Parker of Mt. Vernon. Sister Simonette, administrator, presented plaques to the two Centralia physicians honoring their long association with the hospital.

Dr. Herbert J. Levine, Marion County Medical Society president, was master of ceremonies. He introduced Gov. Stratton as a guest and with Dr. Morris Zelman of Mt. Vernon, presented engraved plaques to the Governor in recognition of his contributions to the medical profession and the welfare of Southern Illinois. The Governor received a standing ovation.

Research Fellowships. In its fifth year of a five-year Federal program to increase manpower for research in the preclinical sciences, the U.S. Public Health Service's National Institutes of Health announced the award of 44 five-year Senior Research Fellowships. Illinois recipients of these fellowships are William R. Martin, Department of Microbiology, University of Chicago; Renato L. Baserga, Department of Pathology, and Robert C. Parlett, Department of Microbiology, both of Northwestern University. The program, administered by the Division of the General Medical Sciences, provides partial support of promising young scientists in the period between completion of their postdoctoral research training and their eligibility for permanent academic appointments. The fellowships are approved by the Senior Research Fellowship Selection Committee composed of deans of medical schools and heads of university departments concerned with research and teaching.

Ricketts Memorial Award. Dr. Karl F. Meyer, one of the world's outstanding authorities on diseases of wild animals transmittible to man, received the 1960 Howard Taylor Ricketts Memorial Award of the University of Chicago on June 6. He delivered the annual Ricketts Lecture on "Plague in the Light of Newer Knowledge." Dr. Meyer is a pioneer in the investigation of sylvatic plague. He is director emeritus of the Hooper Foundation for Medical Research and professor emeritus of experimental pathology of the University of California.

Deaths

H. F. Bouyer*, Chicago, who graduated from Meharry Medical College, Nashville, Tennessee, in 1928, died April 11, aged 61. An eye, ear, nose and throat specialist, he was senior attending surgeon at Provident Hospital. He was also a former president of the Cook County Physicians Association and a member of the Citizens' Committee of the YMCA.

Rolando D. Candela*, Chicago, who graduated at Universidad de la Habana Facultad de Medicine y Farmacia in 1943, died November 8, aged 41.

Ebert Clark*, retired, La Jolla, California, formerly of Evanston and Winnetka, who graduated at Rush Medical College, Chicago, in 1916, died April 16, aged 78. Formerly assistant professor of anatomy at the University of Chicago, he helped to establish the government medical school in Manila.

John J. Dahl*, Elmwood Park, La Grange, and Western Springs, who graduated at Northwestern University Medical School, Chicago, in 1941, died April 14, aged 44. He was staff member of St. Anne's hospital and Community Memorial hospital.

William B. Dougherty*, Chicago, who graduated at College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1906, died April 16, aged 81. He was a supervisor for the Board of Health for almost 50 years.

Roden R. Duff, Jr.*, Chicago, who graduated at Creighton University School of Medicine, Omaha, Nebraska, in 1936, died April 15, aged 53.

Arthur E. Kahn*, Cheyenne, Wyoming, formerly of Deerfield, Illinois, and a graduate of the University of Illinois College of Medicine, Chicago, in 1937, died January 21, aged 50.

Samuel I. Kaufman*, Chicago, who graduated at Loyola University School of Medicine, Chicago, in 1921, died April 22, aged 66. He was chief ophthalmologist at Mt. Sinai Hospital, a professor at the Chicago Medical College, and served on the staff at Cook County Hospital.

John A. Lindquist*, Springfield, who graduated at Hahnemann Medical College and Hospital, Chicago, in 1901, died April 15, aged 87.

Louis Litton*, Chicago, a graduate of the University of Illinois College of Medicine, Chicago, in 1924, died April 10, aged 65. He was a founder of Phi Lambda Kappa fraternity at the University of Illinois medical school.

Elmer V. McCarthy*, Chicago, who graduated at St. Louis College of Physicians and Surgeons in 1923, died May 1, aged 63. He was chief of staff at South Shore Hospital, and had been a past president of the South Chicago Branch of the Chicago Medical Society, and a president of the Freedom Club of Downtown Chicago.

Arthur C. Seguin*, retired, Des Plaines, who graduated at Loyola University School of Medicine in 1927, died February 11, aged 64.

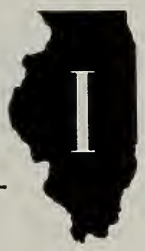
William Christian Spannagel, East St. Louis, Illinois, who graduated at Washington University School of Medicine, St. Louis, in 1903, died January 17, aged 86.

Eric W. Thurston*, retired, La Jolla, California, formerly staff pathologist for St. Mary's Hospital, Chicago, who graduated at St. Louis University School of Medicine in 1929, died April 9, aged 55.

Harry H. Volberding*, retired, Roselle, who graduated at the University of Illinois College of Medicine, Chicago, in 1915, died April 21, aged 69. He had been a member of the staffs of DuPage County Memorial Hospital, Elmhurst, and St. Joseph Hospital, Elgin.

*Indicates members of the Illinois State Medical Society.

BOOK REVIEWS



Soil, Grass and Cancer. By Andre Voisin. Translated by Catherine M. Herriot and Dr. Henry Kennedy. $15. Pp. 302. New York, Philosophical Library, 1959.

When I was asked to review Dr. Andre Voisin's book on Soil, Grass and Cancer, I did not realize the thrill that was in store for me.

I was born and raised on a farm where I believe is the most wonderful laboratory for research—probably one reason this book was of extreme interest to me.

About 45 years ago a colleague and I attended a lecture given by a medical missionary who had just returned from the Congo. After showing slides and discussing some of the cases, he remarked that if there were medical men in the audience he wished to make a statement that would be of particular interest to them. Out of the thousands of natives none had cancer. I remarked to my friend then that cancer was a nutritional disease and that the biochemists were the ones who were going to have to work out the solution to the cause of it. It has developed in the past 40 years that after these natives were on a white man's diet some developed cancer. This also pertains to the Eskimo.

The bibliography covering 428 references is proof in itself of the extensive research that Dr. Voisin has done, and I must say it is worth reading and re-reading, particularly by people interested in cancer.

I can readily understand that there might be some skeptics on this subject, but they are not familiar with the tricks our natural resources which produce our livelihood can play on us. There is just one subject that I think Dr. Voisin has treated rather lightly and that is the electrospectrographic analysis of tissue, food, and soil and their relationship to cancer. May I add here that this same analysis applies to many of our constitutional diseases as cardiovascular and arthritic diseases.

I can certainly recommend the reading and close study of Dr. Voisin's book "Soil, Grass and Cancer" and hope some of the dust stays on you.

G. C. Otrich, M.D.

Christopher's Textbook of Surgery. Edited by Loyal Davis, M.D. 7th ed. $15. Pp. 1511. Philadelphia, W. B. Saunders Company, 1960.

This textbook, as re-edited by Dr. Loyal Davis is a sparkling series of short monographs covering the surgical field in a comprehensive manner.

The list of contributors includes the outstanding teachers of surgery from our leading medical schools. It thus provides an authoritative and up-to-date reference source for the practicing surgeon, as well as a solid body of background material for the medical student. As always, in the writings of strong men, one finds strong opinions which are at times at variance with one's own. This is an asset rather than a detriment, and on the whole, there is no question that this volume represents a brilliant contribution to the teaching of surgery.

Paul V. Harper, M.D.

Drugs of Choice, 1960-1961. 2nd ed. Walter Modell, M.D., Editor. Pp. 958. Price $13.50. St. Louis, Mo. C. V. Mosby Company, 1960.

This second edition establishes a two-year interval as the frequency for revision of this book to provide current unbiased selection of the most suitable drugs for the ills of man. Forty-seven contributors outline clinical considerations sketchily, describe favorable and toxic actions of selected drugs, and evaluate what may be expected from their use to treat disease. Although somewhat disappointing in general, some sections

draw useful conclusions from a wealth of clinical experience with the traditional as well as newcomers in the therapeutic armamentarium. Controversy is avoided by a simple statement of the contributor's individual preference. Unsuitable for the student or expert, it will have some value for the practitioner who has been unable to maintain his therapeutic perspective in a deluge of new drugs provided by our pharmacological colleagues.

W. H. Wehrmacher, M.D.

Textbook of Otolaryngology. David D. DeWeese, M.D., and William H. Saunders, M.D. $8.75. Pp. 464, with 354 illustrations. St. Louis, Mo. The C. V. Mosby Company, 1960.

The authors have brought forth a textbook designed primarily for the medical student and the general practitioner. They have purposely limited the discussion of anatomy and physiology so as not to over-burden the reader. Each of the thirty-two chapters ends with a number of selected references to provide additional information. In covering the broad field of otolaryngology they have included many of the advances of the past quarter of a century, especially in the field of hearing (thirteen chapters on the ear). Details of surgical technics of otologic procedures may be somewhat out of the pale of intended readers but nevertheless may serve to acquaint them with the scope of modern surgery. The same comment may be made about rhinoplastic procedures.

The line drawings depict steps in the performance of surgery. Symptoms such as nosebleed, hearing loss, tinnitus, dizziness, and vertigo are given over to separate chapter consideration. Notable for their completeness are chapters devoted to discussions of speech disorders and rehabilitation of persons with hearing loss.

Francis L. Lederer, M.D.

Anatomy — A Regional Study of Human Structure. Ernest Gardner, M.D., Donald J. Gray, Ph.D., and Ronan O'Rahilly, M.S., M.D. $15. Pp. 999. Philadelphia and London, W. B. Saunders Company, 1960.

For a quarter of a century there have been several attempts to introduce a shorter textbook of gross anatomy, more consonant with what a student can be expected to learn in a discipline that has suffered progressive curtailment from two full years to a half year, or less. Despite a fair number of adoptions of these shorter books, the standard texts (Gray, Morris, Cunningham) still hold the lead. Admittedly, among the by-products from the use of oversized books by beginners, there is a certain gain since, from the start, the student is forced to learn how to read selectively, winnowing the chaff from the grain for his needs. In truth, this is precisely what must be done throughout a scholar's life and, without practice, no one has an innate ability to do it judiciously. It is reasonable to conclude, nevertheless, that a short course in gross anatomy serves its purpose best if it sets as the prime objective the conveying of clear concepts of fundamentals. Hence, a sound book aimed toward this end should theoretically be best suited to aid in such an endeavor.

The present text, written by three experienced teachers at Stanford and Wayne State universities, is a notable attempt to fill this need. The avowed major aims are (1) to provide a text sufficiently brief; (2) to supply information on living anatomy, stressing the relationship of structure and function; and (3) to introduce abundant references as footnotes and bibliographies in order to show how anatomy is a growing discipline and where new information can be found. Radiographic anatomy is also well treated. The plan of presentation is basically regional, to conform to the customary program of dissection, but many general topics of a systematic nature are treated in introductory chapters. Illustrations are line drawings, except for numerous radiograms. Although plentiful and valuable, they do not attempt to supplant the concurrent use of an anatomical atlas.

Unlike the treatment customary in large texts, histology and neurology as such have been omitted. On the other hand, since comparative anatomical and developmental information is now often acquired by the student before he reaches the medical school, some relevant information on these matters is interjected at appropriate places. This new work offers a tantalizing display and distillate of old wine in a new bottle. Moreover, the manner of presentation is refreshingly novel and modern. It should be an interesting and even exciting book to a new student. It will surely prove a revelation to the practitioner who has never known other than the old-time, standard texts.

Leslie B. Arey

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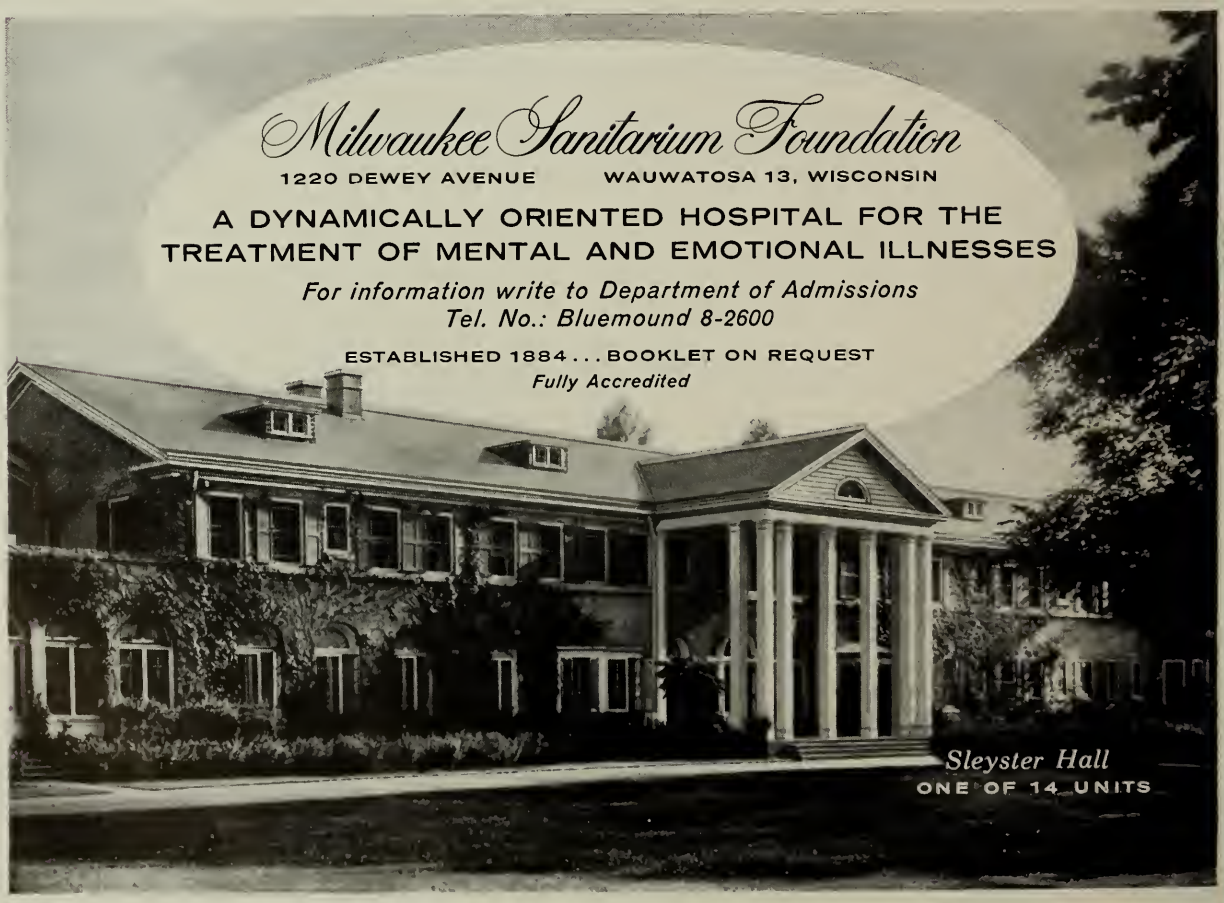
What price security?

Reduced to its lowest terms, the maximum security enjoyed (?) by any individual is that of the felon in a state penitentiary. He does not have to worry about where his next meal comes from, his raiment, or his medical care. Neither does he have to consider the possibility of being robbed at night, for not even the boldest thief would try to burglarize the building which houses the felon. Some might consider this ultimate in security overdrawn, but it is at least realistic.

America did not become great by the security of the individuals who builded the republic. In truth the colonists and their descendants for generations were anything but secure. They depended upon their own strength, their sagacity, their will to work, their muskets, and their hunting knives for security. But as time has gone on, as the primeval wilderness has been subdued, and as wealth has been amassed, the socialistic ideas of Europe have penetrated our thinking, and we are becoming infiltrated with the concept of the state as all powerful and the individual citizen as a craven weakling. *Editorial. Security: Blessing, Fetish, or Snare? West Virginia M. J. Nov.* 1959.

Arterial shunts

It must be concluded on the basis of present evidence that best results (in the surgical treatment of peripheral arteriosclerosis obliterans) can be expected in by-pass shunts of microcrimped dacron or teflon or in thromboendarterectomy, performed in cases with adequate run-off. Conditions suitable for surgery will be present in some 25 to 60 per cent of cases. Immediate restoration of circulation can be expected in somewhere between 65 and 95 per cent of operated cases, while late failure will occur in 10 to 80 per cent of those having immediate success. The evidence is still equivocal, and the paucity of reports and the slowness with which they are appearing would suggest that success in this area is still of a limited nature. *S. J. Goldowsky, M.D. The Present Status of Peripheral Arterial Reconstruction for Arteriosclerosis Obliterans. Ann. of Med. Jan.* 1960.



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REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

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Common sense in practice

If the technique of reducing ideas to a simple form, and placing them in logical order, were carried out extensively, only a few of our clinical ideas would come through unscathed.

Even with research, a good deal of the reasoning is put in after the discovery has been made. Sir Charles Dodds once compared research to the progress of a man stumbling across a dark room, trying to find the light switch and upsetting the furniture as he goes. Once he has found the switch and the light is on, he goes back and puts all the furniture tidy again.

It is important to recognize that things are much easier to believe if they are comforting, and that many clinical notions are accepted because they are comforting rather than because there is any evidence to support them.

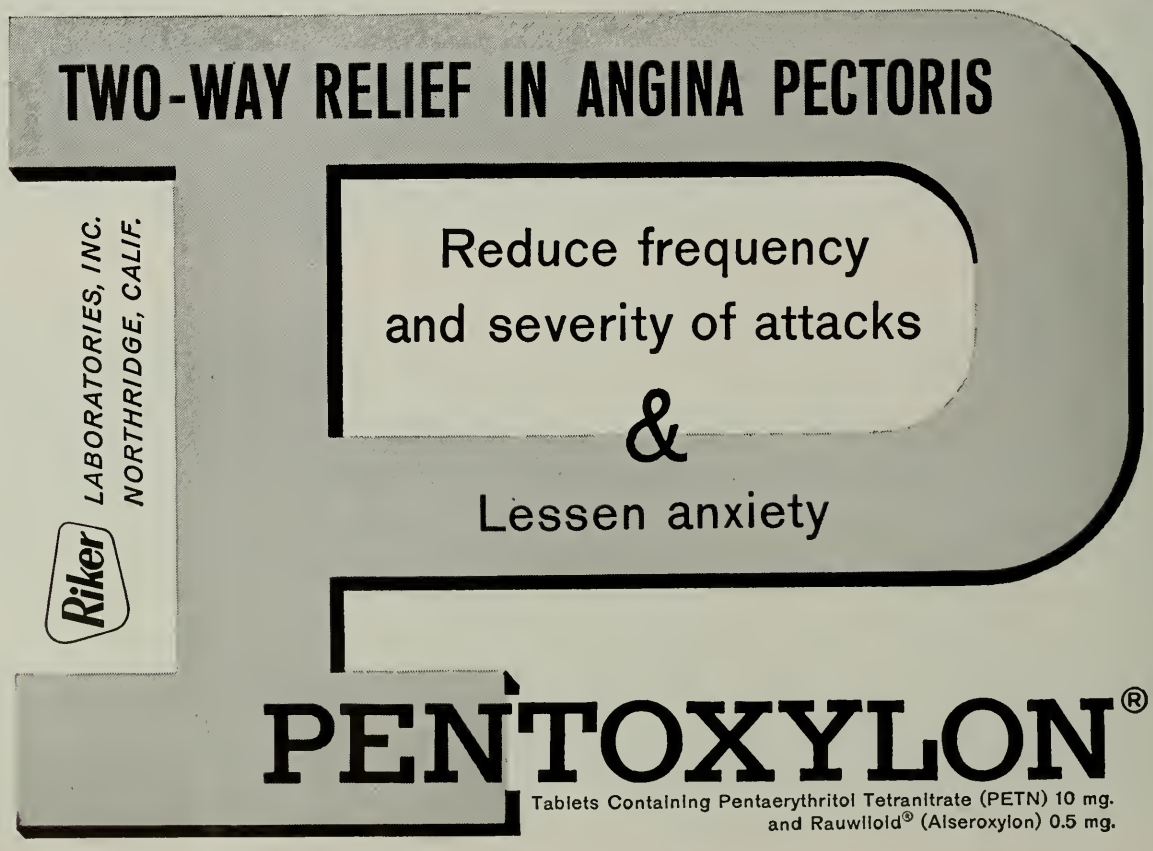
The majority of worth-while doctors are driven to a compromise in which they muster enough genuine belief in their treatment to keep their patients happy and maintain their own self-respect, while preserving enough doubt to admit their inadequacy during transient bouts of uncomfortable honesty.

I can only reiterate Allbutt's words: "Our path is cumbered with guesses, presumptions and conjectures." I turn with relief to the more solid ground of common sense—the capacity to see the obvious even amid confusion, and to do the obviously right thing instead of working to rule. *Asher, R. Talking Sense. Lancet. Sept. 26, 1959.*

Self-hypnosis and pain

One patient underwent an appendectomy with open-drop ether and pulled her head out of the mask to agree to the surgeon's remark that this was a good anesthetic. Another patient underwent a cesarean section and closure of the wound with nothing more than the oxygen coming through the mask which has been placed while the abdomen was being prepared. Another patient underwent incision through the peritoneum and through the uterus for cesarean section with presumed pentothal anesthesia. The surgeon, Joe Brancamp of Butte, Montana, had infiltrated the skin and fascia with novocain. He had signalled for the anesthetist to start

(*Continued on page 66*)



IN CONTRACEPTION...



PHOTOGRAPH: HUMAN SPERMATOZOA 400X. HEMOCYTOMETER DIFFUSION TEST.

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Self-Hypnosis (Continued)

the intravenous pentothal, but the anesthetist had missed the communication until the baby had been removed from the uterus. In this, as with the other cases, the expectancy that there would be no pain was responsible for the result. It is further probable that the preoperative aura of fear tends to promote a hypnoidal state in which pain tolerance is naturally elevated. It is well known that a boxer can suffer severe injury during a match without feeling pain, that the injuries of an automobile accident are painless at first. It is clear from investigations which will be subsequently reported, that human beings escape into hypnotic states when jolted or greatly frightened. *David B. Cheek, M.D. What Does the Surgically Anesthetized Patient Hear? Rocky Mountain M. J. Jan.* 1960.

Lipstick a political issue

Americans are an oral nation and no mistake. As part of the universal milk-and-honey, there is an immense proliferation of candy, milk-bars, chewing-gum, and cigars. What with Hollywood, teenagers, and baby-dolls, kissing has become the major industry and a prime raw material for export. But alas! cigarettes are already under sentence, cranberries are suspect, and now another subtle blight has fallen on the unhappy land. Long-suffering rats, painted year by patient year with lipstick dyes, have at last developed tumours. Suddenly the American skies, the biggest and bluest ever, are darkened. Lipstick is out, goodbye glamour. Whatever will be the effect of it all? The women's strike fomented by that arch-shop-steward Lysistrata averted war, certainly; but probably only because the men were too busy arguing with their wives to fight the enemy. What will happen now that oral aggression can no longer take its rightful avenue? Shall we see a bitter outburst of frustrated verbal savagery and a renewal of international discord, or will there merely be a boom in American milk-sales? *Commentary. In England Now. Lancet. Jan.* 2, 1960.

By the street of By-and-By, one arrives at the house of Never.—Cervantes



from the New England Journal of Medicine:

"The most striking result of this [Singoserp] study has been the relief of the undesirable side effects produced by other rauwolfia preparations."*

*Bartels, C. C.: New England J. Med. *261*:785 (Oct. 15) 1959.



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Side Effects	Incidence with Prior Rauwolfia Agent	Incidence with Singoserp
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Atherogenesis

In America, as Holman in New Orleans and Lober in Minnesota have shown, atherogenesis in white males is most rapid between the ages of ten and twenty-five years. American dietary surveys show an incredibly high intake of dairy and egg fat by white males during these years, but no corresponding increase in either dietary fat or in atherogenesis in white girls. While dietary surveys and studies of arteries in European adolescents have not been published, it is apparent in discussing the problem with European parents and pathologists that it is in this age group that a great difference from the American population is seen. Boys rarely have eggs or cream for breakfast or lunch; they consume little ice cream and do not drink milk. Their load of school work and modes of travel to school force them to a life which favors high caloric expenditure with a diet actually lower in animal fat than the diets of their parents (who have much more substantial mid-day meals). *William Dock, M.D. Editorial. Diet and Atherosclerosis: Significance of Exceptions That Test the Rule. Amer. J. Clin. Nutr. March-April 1960.*



My! What a long ankle you have!

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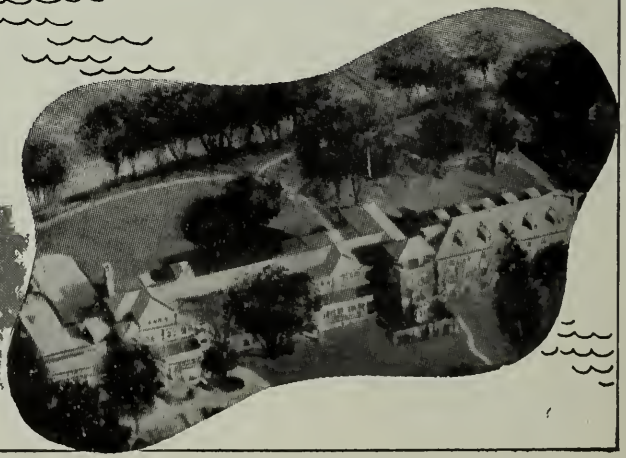
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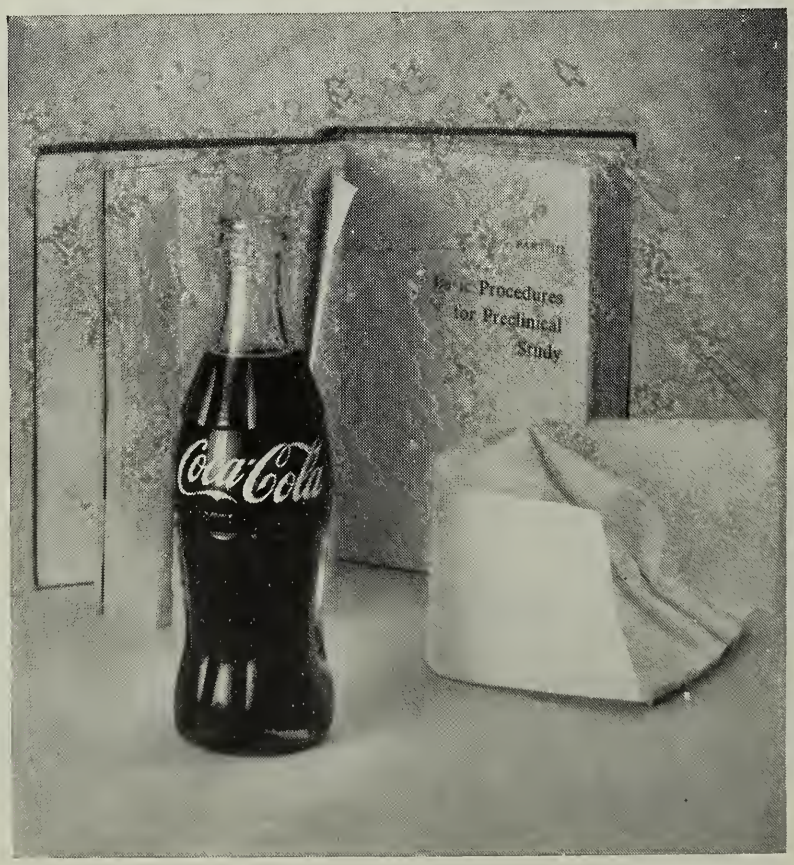
CM-2056

Crucified on the T-wave

If this paper has a raison d'etre, it is to emphasize the importance of the cervical radicular syndrome in the differential diagnosis of chest pain that may be confused with coronary heart disease. Every physician has seen the sorrowful example of the patient with the misdiagnosis of coronary heart disease. He often becomes a "noncardiac" cardiac cripple — afraid to move, afraid to work, afraid to live. Not only is the label of coronary heart disease difficult to eradicate from the patient's mind when once made, but the entire future of that patient's life is often irrevocably altered. For example, once a patient has the label of coronary heart disease, it is often impossible for him to obtain life insurance at a normal rating in spite of subsequent negations of the original diagnosis. In this regard, it is regrettable that frequently the diagnosis of coronary heart disease is made or implied by minor, nonspecific changes in the electrocardiogram alone. The number of persons that have been literally crucified on inverted T waves must be large indeed! Likewise, there are undoubtedly many individuals with the cervical radicular syndrome who have received the erroneous diagnosis of coronary heart disease.

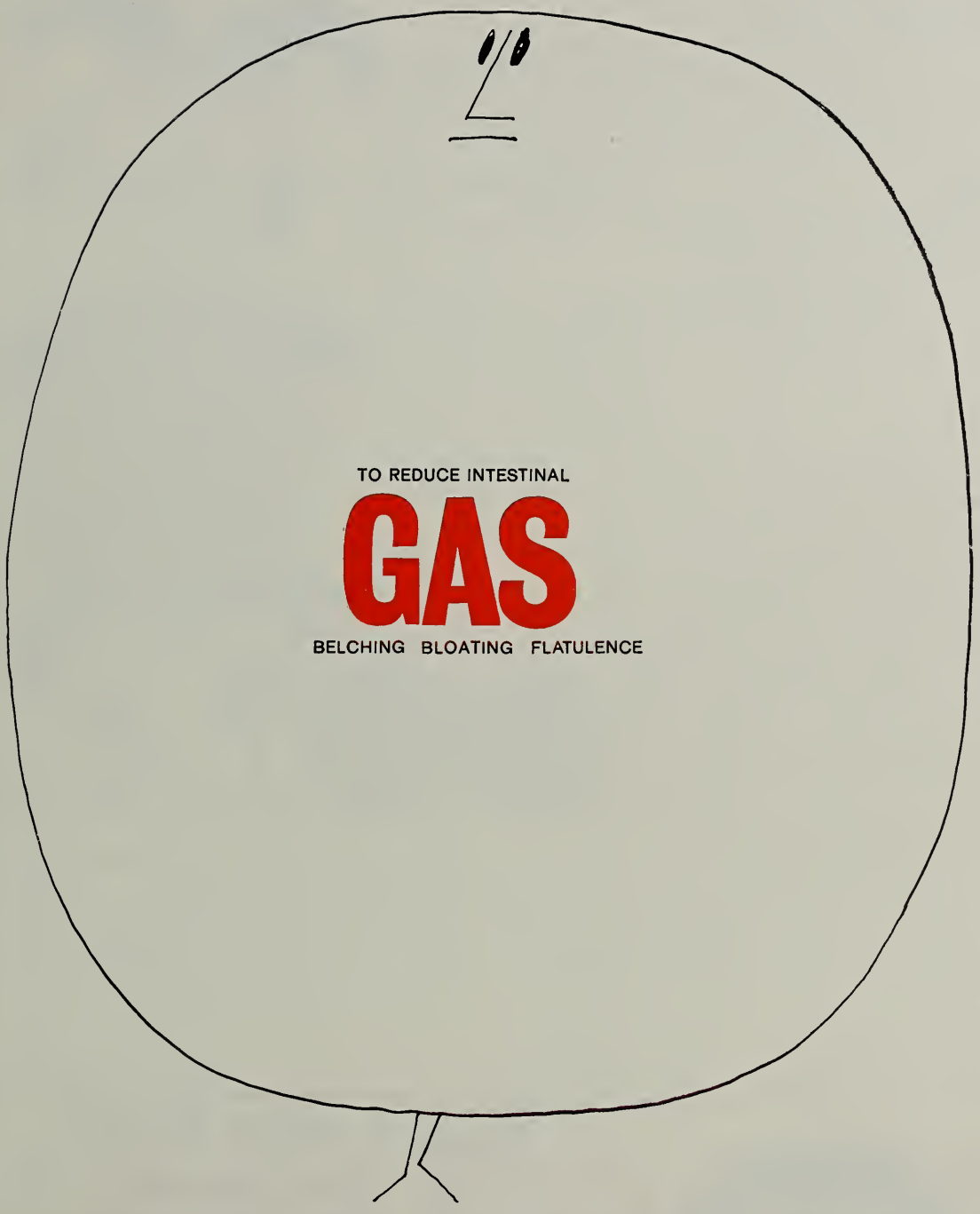
The features enumerated above, especially a careful history and physical examination, will usually allow the physician to make a correct differential diagnosis. In discussing the differential diagnosis of thoracic pain, T. J. Dry aptly summed it up when he said, "Despite all the helpful data which can be derived from the various diagnostic procedures, there is no alternative to skillful interrogation of the patient." *R. D. Story, M.D., and R. D. Schrantz, M.D. Cervical Spondylosis (Osteoarthritis) Simulating Coronary Heart Disease. J. Lancet. March 1960.*

Some day, in years to come, you will be wrestling with the great temptation, or trembling under the great sorrow of your life. But the real struggle is here, now, in these quiet weeks. Now it is being decided whether, in the day of your supreme sorrow or temptation, you shall miserably fail or gloriously conquer. Character cannot be made except by a steady, long-continued process.—Phillips Brooks



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Heredity and metabolism

The primary malabsorption syndrome, according to our present thinking, is a genetically-transmitted complex metabolic disorder. From the clinical aspect, it is mainly characterized by intestinal malabsorption and hematologic abnormalities. It involves, however, many other metabolic disturbances and affects the metabolism of proteins, carbohydrates, lipids, electrolytes and water and may be hematopoietic, which is not necessarily related to the difficulties in absorption. Profound disturbances in genetically-controlled enzymatic chain reactions seem to affect intestinal absorption mainly in the wall of the gut as well as the metabolic pathways of many factors mentioned above.

Based on the genetic anlage, the malabsorption syndrome may become manifest at various periods of life: in infancy or childhood (as celiac disease) or later in life as tropical or non-tropical sprue. Having produced manifestations in childhood, the disorder may go underground for many years or may never again produce manifestations of malabsorption. As in many other hereditable metabolic errors, there is a steady interplay of the genetic predisposition with environmental influences which may both stimulate and mitigate manifestations of the disorder. Distress of tropical climates, malnutrition, and infections are important environmental factors which may convert a predisposed person into a patient with manifest malabsorption syndrome. Strong emotional factors may play a similar part. Whether wheat or rye gluten represents a dietary triggering mechanism or is more profoundly involved in the basic metabolic defect (pterylglutamate complex) of primary malabsorption remains to be established. *David Adlersberg, M.D. Classification of Malabsorption Syndrome. Am. J. of Clin. Nutr. April 1960.*

The practical man is the adventurer, the investigator, the believer in research, the asker of questions, the man who refuses to believe that perfection has been attained . . . . There is no thrill or joy in merely doing that which any one can do . . . . It is always safe to assume, not that the old way is wrong, but that there may be a better way.

— Henry R. Harrower

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A look into the future

It requires but a modest degree of imagination to project the trends described into the future. Technical improvements finally will permit isolation and characterization of such heretofore reluctant agents as the viruses of hepatitis, infectious mononucleosis, and even the common cold. As the result of progressive—and not yet fully understood—changes in environmental factors, two types of change in disease occurrence may be expected to continue. Age patterns of infection with certain known and rather prevalent viruses may shift with a resulting change in the nature and frequency of disease. Mumps and rubella, for example, may become common as adult diseases with greatly increased significance. Or, some of the newly recognized enteroviruses of apparently low present pathogenicity may repeat the polio story. The emergence of truly new diseases also may be expected to continue, not only from the already explored arthropod reservoir but also from an equally vast reservoir which must exist in lower vertebrates.

Further, the number of viruses adventitiously detected in relation to man will continue to increase, and slowly certain of these will be revealed as true pathogens, responsible in each case for some small segment of the mass of as yet undifferentiated infectious disease—respiratory illness, diarrheal disease, aseptic meningitis, and plain "fevers of unknown origin."

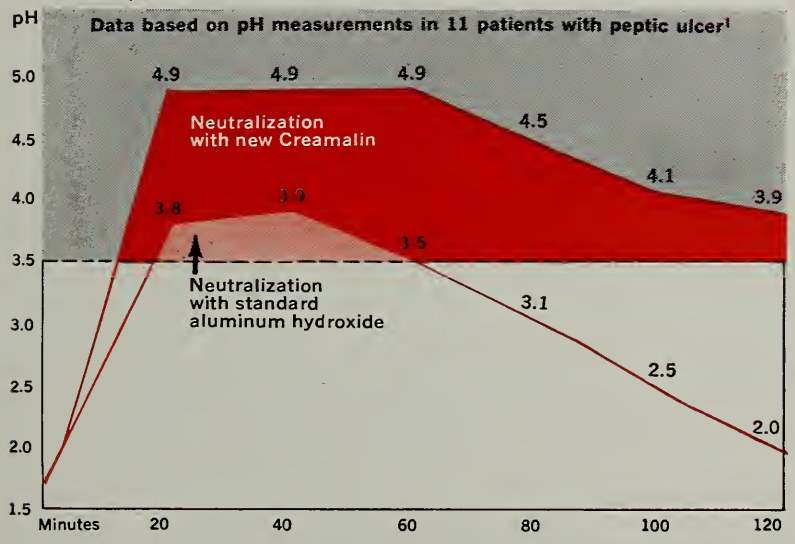
Finally, it seems inescapable that viruses will be related to at least certain human cancers. It is unreasonable to think that special mechanisms have been contrived only for lower vertebrates. The various forms of human leukemia, lymphatic tumors including Hodgkin's disease, at least some mammary cancers, and perhaps bladder tumors provide close analogies to tumors of animals already shown to be caused by viral agents.

Going somewhat further, and based only on the inherent similarities of the whole array of malignant tumors which suggest some common denominator in their causation, it is my conviction that viruses may prove to be essential to all cancer. In some instances, it may be that only viral infection is needed. In others, it may be that other influences—chemical carcinogens or irradiation—are necessary inciting factors. *John P. Fox, M.D. Virus Infections and Human Disease Past, Present, and Future. J. Mississippi State M. A. March, 1960.*

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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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Index to Volume 118
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Bibliography: (1) Scott, J. S., & Kellaway, P.: *M. Clin. North America* 42:415 (March) 1958. (2) Ganoug, L. D., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, pp. 98-102. (3) Bray, P. F.: *Pediatrics* 23:151, 1959.

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The Month in Washington



An omnibus bill approved by the House Ways and Means Committee contains two provisions of major importance to physicians—social security coverage for doctors and a Federal-state program to provide health care for older persons with low incomes.

About 150,000 self-employed physicians would be covered by social security on the same basis as lawyers, dentists, and other self-employed professional people now are covered. Becoming effective for taxable years ending on Dec. 31, 1960, or June 30, 1961, self-employed physicians would be required to pay a social security tax of 4½ per cent of the first $4,800 of income. Physicians also would be subject to the automatic increases in the social security tax in future years.

Medical and dental interns would be covered for the first time also.

Rep. Wilbur Mills (D., Ark.), chairman of the Ways and Means Committee, was the main architect of the health program for "medically indigent" aged. It was designed to provide a broad range of hospital, medical and nursing services for persons 65 years of age and older who are able financially to take care of their ordinary needs but not large medical expenses.

It would be up to each state to decide whether it participates in the program. The extent of participation—the number of benefits offered to older persons—also would be at the option of individual states.

The states would determine the eligibility of older persons to receive benefits under the program. However, the legislation laid down a general framework for eligibility: persons 65 years and older, whose income and resources—taking into account their other living requirements—are insufficient to meet the cost of their medical care.

The program couldn't become effective until July 1, 1961. Before putting such a program into effect, a state would have to submit to the Federal government a plan meeting the general requirements outlined in the legislation.

The program would be financed by Federal grants matching those of participating states on the same basis as under the present-old age assistance formula.

States could elect to provide, with Federal financial aid, any or all of the following benefits:

1) Inpatient hospital services up to 120 days per year; 2) skilled nursing-home services; 3) physicians' services: 4) outpatient hospital services; 5) organized home care services; 6) private duty nursing services; 7) therapeutic services; 8) major dental treatment; 9) laboratory and x-ray services up to $200 per year, and 10) prescribed drugs up to $200 per year.

The committee put a $325 million price tag on the program for the first full year of operation --$185 million Federal and $140 million state. However, this estimate could hardly be more than an educated guess of sorts. The actual cost would depend upon unpredictable factors—how many

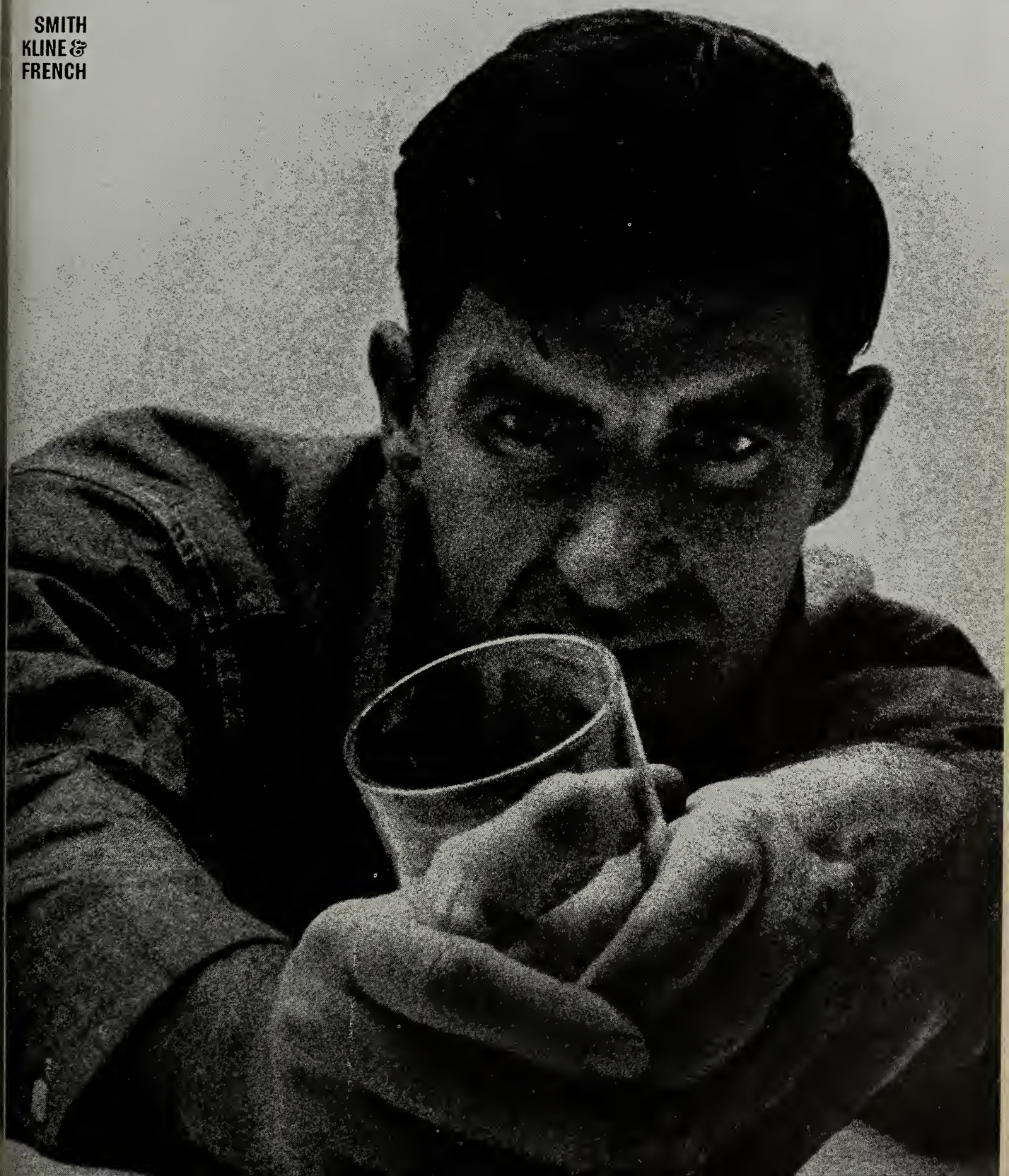
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WASHINGTON (Continued)

states would participate, how many benefits they would offer, and how many older persons would qualify and what services they would require.

The committee estimate was based on between 500,000 and 1 million older persons a year receiving health services under the program. If all states participated fully, the committee said, potential protection would be provided as many as 10 million aged whose financial resources are so limited that they would qualify in case of serious or extensive illness.

Payments under the program would go directly to physicians and other providers of medical, hospital, and nursing services.

In addition to the Federal grants for the "medically indigent," about $10 million more in Federal funds would be authorized for payment to states for raising the standards of medical care benefits under present public assistance programs for older persons.

The approach of the Mills program was similar to that of Point 2 of the American Medical Association's 8-point program for health care of the aged. Point 2 stated that the AMA supports Federal grants-in-aid to states "for the liberalization of existing old-age assistance programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency." Such a liberalized definition of eligibility should be determined locally, the AMA said.

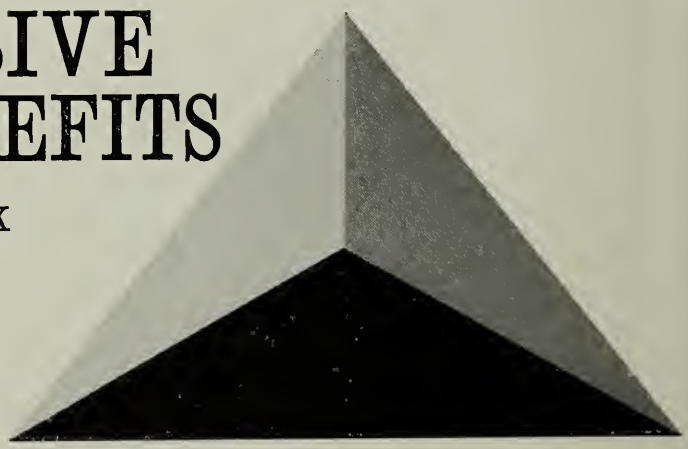
Approval of the Mills plan by the committee marked a sharp setback for organized labor leaders. But they continued their all-out pressure campaign in an effort to get Congressional approval of Forand-type legislation that would use the social security system to provide hospitalization and medical care for the aged. After being defeated in the Ways and Means Committee, labor union leaders and other supporters of Forand-type legislation directed their major efforts to try to get the Senate to substitute the social security approach.

Prior to approving the Mills plan, the committee rejected the Forand bill (three times) and the Eisenhower Administration's far-reaching

(*Continued on Page* 37)

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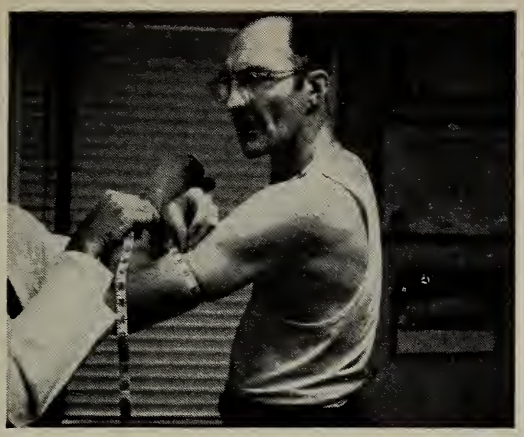
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public assistance alternative. Both plans were opposed by the medical profession and allied groups.

While these legislative proposals were in the limelight, a little-noticed bill was enacted into law to give $50 million in relief to taxpayers burdened with taking care of ill dependent parents.

The new law permits taxpayers full deduction on Federal income taxes for medical and dental expenses paid for a dependent parent 65 years of age and older. Previously, such a deduction was limited to costs in excess of three per cent of the taxpayer's adjusted gross income.

Changes in the Social Security program called for in the catch-all bill approved by the Ways and Means Committee included:—

(1) Eliminate the requirement that a disabled person must be at least 50 years old to be eligible for social security benefits.

(2) Provide social security benefits for about 25,000 widows of workers who died before 1940.

(3) Increase the benefits of 400,000 surviving children of workers covered by social security.

Although all these revisions will increase costs of the program, neither the social security tax rate nor tax base was increased.

The revisions will mark the fifth consecutive year of a national election that the Social Security program, originally enacted in 1935, has been expanded. Some of the expansions have been accompanied by tax increases.

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The Role of the Doctor and Patient In Early Cancer Detection

Warren H. Cole, M.D.,* *Chicago*

As you know, the theme of our conference here in Springfield is Early Detection of Cancer. One might ask, Is this a justifiable subject for detailed discussion, particularly since so much progess is being made in anticancer chemotherapy and other phases of the disease.

Surgery and radiation are fairly effective in the definitive treatment of cancer, and they are the only mechanisms which will cure cancer. The anticancer chemotherapeutic agents cause regression, but with the possible exception of methotrexate for choriocarcinoma, none of these agents is curative. Accordingly, there appears to be ample justification for continuing our efforts to seek the most effective methods of treating cancer, at least until the magic pill to destroy cancer is found. The total yearly deaths from cancer continue to increase, but largely because of a population increase since we are now obtaining cures in 33 per cent of total cases, instead of 25 per cent two or three decades ago.

This improvement in the percentage "cure" rate has been due to three major factors: (1) improved anesthesia, (2) more extensive operations, and (3) better preoperative and postoperative care. Of course, we expect improvement in anesthesia and pre- and postoperative care, but these improvements will be slight and comparatively slow in further development. We cannot expect any improvement from an extension of operations: we are already removing so much adjacent normal tissue with the tumor that removal of any more would jeopardize vital structures. Nevertheless, we can hope to improve results by utilizing principles to minimize the spread of cancer during the operation. For decades we have been aware of iatrogenic dissemination of cancer, but only during the past few years have we been devoting special attention to this hazard.

*Department of Surgery, University of Illinois College of Medicine, Chicago.

Presented at the First Illinois Cancer Congress, March 9, 1960, in Springfield.

All of us agree that if we could use effectivcly available knowledge in the treatment of cancer, we could cure another 10 to 20 per cent of patients. I wish to comment particularly upon the desirability of getting the patient with cancer to definitive therapy earlier.

Overcoming delayed treatment

At present there is far too much delay in obtaining definitive therapy. In a recent study we made of a large series of cases at Illinois Research Hospital, the delay between onset of symptoms and operation was 11 months. Most of this delay can be ascribed to the patient, but often we the physicians are to blame. When a patient comes into the hospital long after onset of symptoms, I usually ask him why he delayed so long, hoping to obtain some information that will help in the problem. The answers are variable but without exception discouraging. Some say, "The tumor gave me no pain so I thought it was not serious." This is often to be construed largely as an alibi, since on many occasions they have already been told by our physicians that the tumor is serious and should be removed right away. On other occasions they say they are "afraid of hospitals and afraid of a major operation." The facts are that in this case we are failing to impress upon the patient the dangers of delay, and failing to overcome the psychologic reasons for procrastination. This problem must be given serious thought and some plan devised to overcome it.

The question has been asked f r e q u e n t l y: Where should cancer detection examination be done? We have a direct answer, but it does not offer a solution to the problem. We would prefer to have these examinations in the doctor's office, but the truth is that there are not enough physicians to examine even a majority of the people should they request an annual examination. In a carefully organized detection center with several physicians and their aides, it appears that more patients could be examined per hour of physician time, and more thoroughly. Accordingly, I think that we should encourage the need for detection examinations in physicians' offices, but should support a small number of detection centers throughout the country. One great advantage of having some detection centers is that they make a lot of lay people aware of the desirability and advantages of frequent examinations.

The American Cancer Society has done much to emphasize the need for frequent examinations for cancer, and has helped considerably in shortening the delay between onset of symptoms and operation. The Self Examination film on breast cancer has probably been the most powerful single mechanism adopted by it or any other group for getting the cancer patient to a physician at an earlier stage. This film has been very popular and draws a large crowd wherever it is shown. With practically no exceptions, after this film is shown in a community, a large number of women go to their doctors for examination of lumps they have discovered. Many lives are saved in this way.

One would think it obvious that the results of treatment following early detection would be superior to results of treatment delayed until the patient decides to go to his physician. However, it is amazing how often a nonconformist will subject data to various types of analyses and present figures to show that results of treatment are just as good in patients having their symptoms for three years as they are in patients having their symptoms for six months.

There are many fallacies in this reasoning. In the first place, many patients will not be alive at the end of three years; this feature alone will pad the results enormously in favor of patients having symptoms for three years or more. I would like to remind you that, with no exceptions, cancer requires time to destroy the patient. This time is variable, and its duration is actually unknown because practically all cancers are present for a certain length of time before symptoms are produced.

It appears reasonable to conclude that every day added to the duration of the tumor approaches by just that much time the day when the tumor will metastasize, and then may not be curable by surgery. This feature becomes increasingly important when we realize that surgery and radiation are the only two mechanisms which will cure cancer, and after a tumor has metastasized the chance of cure is lessened tremendously, particularly if the dissemination or metastases is by way of the blood stream. Surely the fact that each passing day approaches the time when a tumor may disseminate to the point where it is incurable by modern mechanisms would make it obvious that early diagnosis improves results.

Economics and efficiency of detection

We realize that when healthy people of all ages are given cancer detection examinations, the incidence of cancer will be quite low. In a report of 6,754 examinations performed on men and women 1948-1954 in the detection center of the University of Minnesota, Hitchcock and Aust[1] reported cancer in 2.81 per cent of the examinees. This is a bit higher than the incidence reported by other detection centers. Actually, of the 147 cancers found, 79 were symptomatic and 68 were asymptomatic. It was their intention to accept only patients without symptoms, but many with symptoms, mild as they might be, escaped the scrutiny of the admitting office.

Dr. Caesar Portes informs me that in the Cancer Prevention Center of Chicago the cost for examination per patient is slightly over $24. Their incidence of cancer is about 2 per cent. This makes the cost of finding each cancer patient about $1,200. Figures from some other centers have been higher than this. However, if we assume that the chance of obtaining a cure is greatly increased by the early diagnosis, this figure is not prohibitive, especially since a large number of precancerous lesions will be found and removed. So also will numerous other diseases be found; this represents very good preventitive medicine because most other diseases will be found in the early stages when cures will be more readily achieved. In patients past the age of 45, precancerous lesions were found in 28 per cent.

Results with early detection

At the annual meeting of the American Cancer Society in 1959, numerous reports were heard concerning the superiority of the "cure" rate for tumors diagnosed by cancer detection examinations rather than by routine methods. Brown[2] reported on 81 naval personnel with cancer of the lung, 26 of whom were diagnosed during annual examinations. In the group discovered by detection examinations 69 per cent of the tumors were resectable, compared to 49 per cent in the group diagnosed by routine methods, i.e., wating for the patient to go to the physician. The five-year survival rate of these patients was about 20 per cent compared to 5 to 10 per cent for all patients diagnosed by routine methods.

In a series of 1,000 patients with cancer of the breast, Urban noted a five-year survival rate of over 70 per cent for early cases in which the disease was asymptomatic, compared to 52 per cent in the patients having symptoms or a known mass for a variable length of time before operation. Studying patients in their registry, the Westchester Cancer Committee in New York found that 43 per cent of the patients without detectable spread of cancer at the time of diagnosis survived five years compared to only 20 per cent for the patients with detectable spread locally.

Recent analysis by Shahon and Wangensteen[3] of 9,035 patients in the University of Minnesota Cancer Detection Center (1948-1959) reveals a five-year survival rate (in gastrointestinal cancer) of 26.3 per cent for the symptomatic group and 62.5 per cent for the asymptomatic group, or two to three times higher.

In Hitchcock and Aust's series they noted that six of nine patients with asymptomatic cancer of the stomach were alive after five years, compared to only one of five patients with symptomatic cancer of the stomach. In their experience, achlorhydria was a very valuable indication of the presence of cancer of the stomach.

The data assembled above indicates quite clearly that the "cure" rate is much higher in patients whose cancer was discovered by detection examination than it is in patients who came to physicians after manifestations of cancer had developed. These data then justify the cancer detection examination, whether it is carried out in the physician's office or in the detection center.

Prospects for the future

One might ask: When will an agent or mechanism be developed which will be so effective in the cure of cancer that detection examination can be abolished? Af course, no one knows the exact answer to this question. Unfortunately, I do not believe the day when a magic pill will cure all forms of cancer is very close at hand. First, what can we expect of the high powered radiation machines such as the 18 million volt linear accelerator, the 50 million volt betatron, and the 1,200 Curie cobalt bomb? I am told by my radiologist friends that results with these powerful machines have been disappointing. If radiation is to be the solution to the treatment

of cancer, apparently a different type of radiation must be discovered, or ancillary methods devised to make it much more effective.

Surgery is probably the most effective over-all treatment of cancer, but we have already commented on the fact that further improvement in results will be slow in forthcoming, largely because the tumor has so often already metastasized by the time the operation is performed. There is reason to believe that, with the use of ancillary or adjuvant mechanisms, the results can be improved in patients having cancer cells disseminated at the time of operation, or shortly before. This supposition is based on animal experiments indicating that the administration of anticancer chemicals at the time of inoculation of cancers cells will prevent "takes" of the cancer cells; floating cells or cells recently disseminated (but not yet growing as active metastases) are much more sensitive to anticancer agents. We have such strong evidence of this in animals that there seems very little doubt of its veracity in the human being, if the right chemicals are used.

Already experiments are under way to test this hypothesis, utilizing nitrogen mustard, thiotepa, and other drugs at the time of operation. In our own experience with nitrogen mustard, the procedure appears fairly effective in cancer of the breast but not with cancer of the colon and rectum. It appears obvious to us that one agent might be affective with one tumor but not another. Unfortunately, to obtain the maximum benefit from such a procedure, numerous agents would have to be tried with each tumor. Better still, it would be desirable to assay each tumor against several anticancer agents and use the most effective one.

Our next question might be What are the prospects of an effective anticancer agent? In the first place, it is reasonable to predict that an agent for a single cancer will be discovered long before an agent for all cancers will be discovered. I am quite sure that many people in this room will see that day, but not the time when a single drug will cure all cancer. That accomplishment will be more difficult, and will require more than a few years. Actually the very favorable results obtained by Hertz and associates with methotrexate in choriocarcinoma suggest that we may already have the first of these drugs. They have several patients who have had regression for years.

Our next question concerning the future prospects of a cure might be Can we expect vaccines or antibodies to be effective against cancer? We must admit that no more than five or ten years ago even our most distinguished immunology scientists believed that cancer was not antigenic and therefore antibodies could not be produced for cancer. However, during the past few years much data has accumulated indicating that effective vaccines and antibodies can be made for certain animal tumors, and that the human being without cancer has a resistance of some type to it.

Production of immunity in animals

Only during the past few years have workers been able to induce a definite immunity in animals, although experiments in certain laboratories presented evidence years ago that an effective immunity might be possible. Working with a leukemic-like disease in mice, Friend[4] was able to prepare a vaccine capable of preventing transmission of the disease to other mice. She prepared the vaccine by injecting filtrates of spleen of infected mice into rabbits (every three days for three injections), and collected serum from the rabbits 14 to 21 days after the last injection. Of the control mice inoculated with infective material, 84 per cent developed the disease, whereas only 7.2 per cent of inoculated mice treated with the vaccine contracted the disease.

Schwartz and associates[5] similarly produced a vaccine which would prevent leukemia in C_3H mice inoculated with cell-free brain filtrate from infected mice. Using a mixture of concentrated filtrate and bacto-adjuvant, they obtained immunization by injecting the material subcutaneously three times into rabbits at five-day intervals, and collected serum from the rabbits 10 days after the last injection. About 80 per cent of their control mice inoculated with cell-free brain filtrate or tumor-cell suspension developed leukemia, whereas only 10 per cent similarly inoculated with infective material, but also with the rabbit antiserum, developed the disease.

Immunity in the human being

Perhaps the first concrete evidence that antibodies to cancer can be produced by the human being was offered by Graham and Graham[6] in 1955. With a technic using the complement fix-

ation test, they found that 12 of 48 patients with cancer had circulating antibody to their own tumor. In these cases the titer ranged from 1:16 to 1:128. For some reason difficult to explain, a significant titer was found in six patients only after the tumor had been excised. It was very significant that the patients with antibodies had early lesions, which were readily operable. Patients not having antibodies had far advanced lesions. More recently these same authors report the use of a vaccine made from the patient's own tumor. They mixed a suspension of the patient's own cells (or a whole tumor hemogenate) with an equal volume of Freunds adjuvant and injected this into the patient. They reported on the use of this vaccine in 101 patients. There was no adequate mechanism of controlling this experiment, but the authors were definitely of the opinion that many of the patients were improved and had their lives prolonged.

The work of Southam and associates[7] offers fairly good evidence that some type of resistance to cancer is present in most people. They inoculated individuals (their own patients and inmates of the Ohio State Penitentiary) subcutaneously with human cell lines obtained originally from human tumors. These inoculated cells grew in most of the patients having active cancer, but when the cells were injected into young healthy people (prison inmates) they failed to survive in a single person. This indicates that young healthy people possess some type of immune factor which will reject and kill inoculated cancer cells, but patients with advanced cancer do not possess this immunity.

Are predictions possible?

No one is able to predict when a curative agent or mechanism other than surgery and radiation will be discovered. However, data just presented indicating that effective vaccines can be made against animal leukemia give us hope for similar gains in at least one or two types of human cancer within the next few decades.

The increasing amount of data indicating that human tumors are antigenic and that some type of resistance is present in healthy young people likewise makes us optimistic that antibody therapy will some day be effective at least against a few tumors. Although thousands of chemicals have been assayed without any (with the possible exception of methotrexate for choriocarcinoma) appearing to have curative qualities, I feel positive better drugs will be found and that they will be curative against at least a few tumors. However, I doubt that the discovery of a magic pill sufficiently effective to destroy all cancer can be expected for quite some time, perhaps several decades.

REFERENCES

1. Hitchcock, C. R. and Aust, J. B.: Diagnosis of Asymptomatic Malignant Disease. Postgrad. Med. 17:145-156, 1955.
2. Brown, R. B.: The Value of Periodic Examination in Detection of Early Lung Cancer. Presented at the annual meeting of the American Cancer Society, October 1959. To be published.
3. Shahon, D. B. and Wangensteen, O. H.: Evaluation of Early Diagnosis of Cancer of the Gastro-intestinal Tract. Presented before the annual meeting of the American Cancer Society, October 1959.
4. Friend, C.: Immunological Studies on a Filterable Agent Causing a Leukemia-like Disease in Mice. Proc. Am. Assn. Cancer Res., 2:304, 1957; Cell-free Transmission in Adult Swiss Mice of a Disease Having the Character of a Leukemia. J. Exper. Med., 105:307, 1957.
5. Madinos, B. T., Schwartz, S. O., Schoolman, H. N.: Studies in Leukemia: XI Active Immunization of C_3H X 101 Mice Against Induction of Leukemia. Proc. Soc. Exper. Biol. & Med. 99:222, 1958.
6. Graham, J. B. and Graham, R. M.: Antibodies Elicited by Cancer in Patients. Cancer 8:409, 1955; Graham, J. B. and Graham, R. M.: The Effect of Vaccine on Cancer Patients. Surg. Gyn. Obst., 109:131, 1959.
7. Southam, C. M., Moore, A., and Rhoads, C. R.: Homotransplantation of Human Cell Lines. Science, 125:158, 1957; Southam, C. M. and Pillemer, L.: Serum Properdin Levels and Cancer Cell Homografts in Man. Proc. Soc. Exper. Biol. & Med., 96:596, 1957.

Practical Aspects of Cancer Detection

*As Seen by a Practicing Physician**

I. Phillips Frohman, M.D., *Washington, D. C.*

Cancer detection is cancer diagnosis before the appearance of symptoms. This early diagnosis and early treatment constitute the most logical and most effective approach to cancer control. The doctor's office must become a cancer detection center to the best of the physician's ability and knowledge and with the use and application of established methods.

Cancer detection centers and facilities of various types have been established in many communities, and the methods of early, presymptomatic cancer diagnosis have been extensively tested. Two methods, the biopsy and the cytologic smear, are our most practical office procedures.

Raising the cure rates

Not all cancers are accessible for early diagnosis, and some, although diagnosed early, have already extended beyond the range of curability. In spite of these limitations, striking improvements in cancer cure rates can result from the use of accepted methods of cancer detection and early diagnosis by the practicing physician.

The present over-all cure rate of 30 per cent in cancer of the uterus could very well be raised to 80 per cent; the 35 per cent cure rate of cancer of the breast could and should be raised to 60 to 70 per cent; the cure rate in cancer of the rectum now at a meager 15 per cent could be raised to 75 to 85 per cent; and the insignificant 5 per cent cure rate of cancer of the lung could be raised to 30 to 40 per cent if every practicing physician in this country did an all-out job in performing and advocating cancer detection in his daily work. Such effort should result in an estimated saving of 100,000 lives each year.

The practicability for cancer control and detection by the practicing physician depends upon those methods he can use without the use of very special equipment or group organization. The volume and effectiveness of any cancer detection procedure in the hands of the majority of physicians will depend upon its inexpensiveness and simplicity. We have such procedures.

Available inexpensive procedures

The least expensive of all is the routine history taking, including a review of the family history of cancer, personal history of tumors or exposure to environmental carcinogens, and thorough functional evaluation of each body system. The next inexpensive procedure is use of eyes and hands to see those portions of the body that can be visualized superficially or by the aid of endoscopic instruments, and to feel that which can be palpated.

The physical examination should include inspection and palpation of the skin, lymph nodes, thyroid gland, breasts, adbomen, and genitalia. Examination of the oral, nasal, and pharyngeal cavities and vocal cords should follow; then careful and studied auscultation of the lungs (and heart), bimanual pelvic examination, and digital examination of both the rectum and the prostate gland. Vaginal and cervical cytologic smears should be taken, and a proctologic (proctо-sigmoidoscopy) examination should be done on all patients over 40 years old if possible.

Simple methods of laboratory testing have made it imperative and inexcusable for any practicing physician not to do the following: complete blood count, complete urinalysis especially searching for red cells, and stool specimen examination after two or three days of meat-free diet in the search for occult blood. Roentgenographic examination of the chest should be a

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must for all these patients. Bizarre and non-specific shadows in the chest film are troublesome to diagnose even by the experienced roentgenologist; therefore the non-radiologist should in all instances have the advice of the radiologist for those films with questionable shadows.

The basic cancer detection examination properly systemized requires about one-half to one hour, depending upon the quality and number of office aides employed. When the physician reviews data from the history, physical examination, laboratory, and x-rays, he will find cancer in one-half to one per cent of his presumably well adults. In older age groups the percentage will be substantially higher.

Fateful waiting

Maximum cancer detection depends first upon a high level of suspicion on the part of the practicing physician. A good rule of thumb would be that any suspicious or questionable finding is cancer until proved otherwise. Don't wait until tomorrow to see what happens to the small mass in the breast, the encrusted hyperplastic area on the side of the nose, a melanoma-like area under the arms or between the toes, or anywhere else for that matter.

Watchful waiting in the field of cancer detection should be as frightening to the practicing physician as would be the watchful-waiting approach to a highly inflamed appendix ready to rupture. Watchful waiting to "see what happens" often permits development of an early and curable cancer into a late and incurable one. Let me caution you that negative diagnostic tests cannot be considered prima facie evidence that cancer is not present in the face of persisting clinical suspicion of malignancy.

At a meeting, such as this one, dealing with cancer detection, a well-known professor of surgery at one of our large Eastern medical colleges and cancer clinics was asked the question, "Should all breast tumors be removed?" He answered, "At our clinic we evaluate breast masses, and then we biopsy or remove the ones we believe most likely to be malignant." We were shocked by this statement! This was a delusion of his professional brain. In my presentation I had stated that all breast masses should be removed for microscopic examination.[1] I told of my patient who had had two previous masses removed from the right breast, both benign cysts, but the third mass in the same breast six years later was definitely malignant. It would have been very easy to pass this third mass off as a replica of the first two — and thereby have a deceased patient rather than the healthy one I have today.

Some physicians believe that they have uncanny ability and fingertips with microscope objectives that enable them to distinguish between benign and malignant masses in the breast. They could not be more incorrect in their self esteem. It is well known, and very unfortunately substantiated by hundreds of reports in the literature, that among those patients with tumors as small as a pea, two-fifths followed for periods exceeding five years eventually died of breast cancer.[2]

Final diagnosis of cancer must always be made by microscopic examination of a tissue specimen. A representative specimen should be obtained from surface lesions by scalpel or cutting forceps. For those lesions below the surface, needle aspiration biopsy can be effective, but it must be stressed that a negative report of a needle biopsy specimen does not rule out cancer. For lesions of the viscera, such as the lung, stomach, rectum-colon, or bladder, biopsy through the endoscope may be successful. In many instances to arrive at a correct diagnosis, exploratory thoracotomy or laparotomy should be performed promptly. These procedures in experienced hands may be the only means of reaching a suspicious lesion or making a correct diagnosis.

Cytologic examination

Cytologic screening of vaginal-cervical secretions, when employed routinely on asymptomatic adult women of all ages, will lead to the diagnosis of cancer in from three to five women per thousand. This is not an insignificant percentage when we consider that we are seeking out a death-dealing disease. Keep in mind that in more than 40 to 60 per cent of proved cases in a screening program, history and physical examination were negative, and that the diagnosis of cancer depended entirely upon the cytologic smear confirmed by biopsy.

About one third of all cancers in women are located in the uterus, and of these, 80 per cent occur in the cervix. Until just a few years ago it was taught that the earliest signs of carcinoma

of the uterus were bleeding between menstrual periods or after menopause, and a watery, serous vaginal discharge. We know now that by the time these signs appear the cancer most likely has been present for a few years. Our important job is to detect cancer of the cervix, or wherever it may be, before abnormal symptoms cause the patient to visit the physician for that specific reason alone.[3]

As a diagnosic adjunct in the presence of symptoms or abnormal clinical findings, cytology affords microscopic study of specimens from lesions that are in a stage too early to be identified clinically or too remote to be reached for biopsy. Much success has been achieved by cytologic examination of exfoliated cells from sputum and bronchial washings,[4] endometrial aspiration, and washings of suspected sites in the gastrointestinal tract.

With the advent of radioisotopes and their use for treatment, diagnosis and research,[5] it was hoped that perhaps here would lie the possibility of a new test for cancer detection. Our expectations for this purpose have not been fulfilled.

The "soft sell"

It is no longer practical nor intelligent for any of us practicing physicians to wait until the patients come to us with noticeable symptoms before we institute a thorough search for possible cancers in the various sites of predilection in the body. One of my colleagues, quite active in our local cancer society, was shaken with disbelief when I told him that I approach all of my female patients, no matter how trivial their complaint, with these questions: "When did you have your last female examination?" "Have you ever had a cancer test?" And for the male: "How much do you smoke?" "Do you inhale chemicals, dust, or other foreign particles at your job?" "When did you have your last chest x-ray?" And for both male and female: "When did you, if ever, have a complete physical checkup?" These questions are being asked quite casually while I am in the process of writing a prescription or two for a simple head cold, a sprained ankle, or an upset gastrointestinal tract. In nearly fifty per cent of the patients thus approached I have been allowed to do further examinations at the same visit, or the patient will agree to an early appointment for a physical examination including laboratory workup, chest x-ray, and cytologic examination of the cervix. Most of you here probably already use this approach, but for those who are backward in the art of medical salesmanship, forget your bashfulness and try this approach. You will be happily astounded at the number of your patients who were just waiting for you to make the "soft sell" for good medical care.

We physicians must be practical. We must suggest and insist upon good medical care and cancer diagnostic tests for our patients for their own good. In so doing we may find our one half to one per cent of cancer, and also many patients with secondary anemia, cystitis, pyelitis, occult blood in the stool, diabetes, tuberculosis, enlarged hearts, cervical erosion, fibroid and other tumors of the female genital tract, hernias, and many supposedly innocuous conditions.

Examinations for children

So much has been written in the literature or presented at medical and cancer meetings, as we are doing here today, dealing with cancer in adults of middle age and beyond, that at times we physicians lose sight of the fact that we must forever consider the cancer-potential in the pediatric portion of our practices.

Cancer and accidents now comprise the two leading causes of death in children beyond the age of two years. Antibiotics and public health prophylactic measures have reduced the toll of infections and infectious diseases in childhood. Cancer, including leukemia, is responsible for approximately 12 per cent of all deaths in children between the ages of 1 and 14 years. The apparent increase in the incidence of childhood cancer is in part the result of decreased mortality from infectious diseases, particularly pneumonia, tuberculosis, meningitis, and diphtheria. There is also evidence of an actual increase in incidence of childhood cancer, particularly leukemia.[6]

The high frequency of malignant tumors found at birth or before the fifth year of life suggests the embryonal nature of the more common juvenile tumors, such as Wilm's tumor, medulloblastoma, and neuroblastoma. Heredity is another factor in the origin of these congenital tumors, and the importance of counseling parents cannot be discounted. Retinoblastoma is one example. Persons who have survived retinoblastoma are likely to have children with bilateral retinoblastomas. Yet later offspring of unaffected

parents who have had one child with retinoblastoma show no greater tendency to be born with this affliction than other children in the general population.

Physicians who treat infants and children, the general physician and the pediatrician, must keep in mind the sites of predilection of cancer in youngsters since these sites differ greatly from those in adults. The common sites of malignant neoplasms are the hematopoietic system, the adrenal gland, bone, kidney, soft tissues, and the central and sympathetic nervous systems, including the eye. Sarcomas occur far more frequently in children than do carcinomas. Rare in early life are the epithelial tumors of the adult, such as carcinoma of the lung, breast, stomach, skin, or uterus.

It behooves us to remember also the general area of the four major groups of the highest incidence including the malignant lymphomas (leukemias, Hodgkin's disease, lymphosarcoma), central and sympathetic nervous system tumors (glioma and neuroblastoma), bone tumors (osteogenic sarcoma and Ewing's tumor) and genitourinary tumors, particularly Wilm's tumor).[7] Each of these tumors appears most frequently in a special period of childhood. Intracranial neoplasms reach their peak incidence between the ages of 5 and 10 years, whereas more than one half of the cases of childhood leukemia occur before the age of 5 years.

Malignant tumors in childhood in many instances arise in the more superficial layers such as the dermis, subcutaneous fat, and skeletal muscles. The presenting feature may often resemble that of a solid mass. Even with large malignant growths, however, anemia, weight loss, and cachexia are not usually prominent. Symptoms arising from childhood malignancies may develop insidiously or precipitously. There may be an acute fulminating onset with tumors of the thoracic cage, the skull, or abdominal cavity. The clinical picture may suggest an acute infectious process. When leukemic cells have invaded the bone marrow, anemia, pallor, fatigue, hemic murmurs, ecchymosis, purpura, and petechiae may be representative of some of the prominent signs and symptoms. There may be enlargement of the liver, the lymph nodes, kidney, or spleen. Mesenteric adenitis, intussusception, and fracture of a vertebra are some of the clinical forms which leukemia may assume.

Therapy, to be effective, depends upon an early diagnosis before irreversible changes or extensive damage has occurred. It is imperative that the physician bear in mind the possibility of malignancy in any child presenting atypical signs and symptoms, especially those that do not fit any particular disease or entity. The solid mass found in the infant or child, as in the adult, must be considered a malignancy until proved otherwise!

A simple general cancer detection test to screen large population groups has not yet been devised. In its absence, effective and practical cancer detection depends upon the thorough examination of the individual patient by established clinical methods and techniques. Many a presumably healthy adult will prove to have minimal symptoms he does not regard as significant. The routine examination brings them to medical attention weeks or months before he would otherwise have sought it.

Educating the patient

Clinical studies and reports substantiate the fact that the vast majority of cancers occur between the ages of 40 to 60 years; therefore it behooves the physician to educate this group of patients in the practicality of routine complete physical examinations each year. It is most important to teach our patients (1) that the initial complete examination with perhaps minimal or negative findings does not establish good health for the next ten or fifteen years, (2) that the routine examination becomes more important as the patient ages. The normal findings during the initial examination enable the physician to detect any slight variation found subsequently. This is, I believe, the most important single practical aspect in cancer detection as we know it today.

REFERENCES

1. Frohman, I. P.: The Role of the Private Physician in the Detection of Cancer of the Breast, Connecticut Med. 23: 447-449 (July) 1959.
2. Kreyberg, L. I.: The Significance of "Early Diagnosis" in Breast Cancer. A Study of Some Common Usages of the Term, Brit. J. Cancer 7:157-165 (June 15) 1948.
3. Frohman, I. P.: Cancer of the Cervix and the General Physician, Med. Ann. District of Columbia 24:539-542 (Oct.) 1955.
4. Frohman, I. P.: The Role of the Private Physician in the Detection of Cancer of the Lung, Connecticut Med. 23: 443-446 (July) 1959.
5. Frohman, I. P.: Radioisotopes and the General Physician, GP 18:75-78 (Oct.) 1958.
6. Vital Statistics of the United States 1956, Vol. 2, National Office of Vital Statistics, U. S. Public Health Service, 1958.
7. Ibid.

Pathological Aspects in the Detection of Cancer of the Lung

Edwin F. Hirsch, Ph.D., M.D., Sc.D.,* *Chicago*

Pathologists in practice during the past forty years have observed the incidence of carcinoma of the lung increase from the time when the disease was encountered as a curiosity in necropsy examinations to now when it is one of the most frequent of the cancerous diseases. Now pathologists in large hospitals examine many biopsy and other surgical tissues in which a real or suspected carcinoma of the lung is the diagnostic problem. Before the advent of the bronchologist with his bronchoscopic instruments, clinicians and pathologists were obliged to approach the diagnosis of carcinoma of the lung with technics similar to those of a guessing game. Tissues submitted for diagnosis usually were those of a metastasis, and from their structure the site of the primary focus was postulated as probably the lungs. Since then, means for diagnosis have been improved by bronchology, radiology, pathology, clinical observation, and interpretation. An earlier diagnosis of primary lesions has followed a general awareness of the prevalence of the disease. Diagnosis stimulated technics for therapy, notably the partial or the complete removal of a diseased lung.

These surgical technics have advanced far beyond the first successful pneumonectomy by Evarts A. Graham; now segmental or complete lobectomies and pneumonectomies by surgeons with special training are common procedures in many hospitals. The pathologists of my generation have participated, at times gropingly, in this progress in the diagnosis and treatment of carcinoma of the lung.

Comments on pathological aspects should be prefaced by some general remarks. Prevailing opinions regard carcinomas of the lung as bronchogenic; that is, they arise from epithelium in the lining or deeper portions of the wall of a bronchus or bronchiole. These cancers occur at any age, but more frequently after 40 years, and in men more often than in women. Chronic cough, pain in the chest, hemoptysis, and purulent sputum are the usual complaints. The first clue may be an abnormal shadow in a routine roentgen film of the chest. Sometimes specific symptoms of the primary focus are minor while those of a metastatic growth are dominant. Local growth of bronchogenic carcinoma produces an obstruction of the bronchus beyond which secretions and exudates accumulate. Bronchiectasis, infection, and necrosis of peripheral lung tissues follow. Hemorrhages in the tumor or infected lung tissues cause hemoptysis.

Through metastases the disease spreads into many tissues: the pleura; the hilar, mediastinal and cervical lymph nodes; the bones, brain, liver, suprarenal glands, kidneys, and elsewhere. Symptoms that metastases produce sometimes bewilder the clinician, and tissues of a secondary growth removed for microscopic study bring the pathologist into the diagnostic problem.

Many bronchogenic carcinomas are near the hilus of the lung but may be at any level to the periphery. They range greatly in size. A bulky tumor casts a large shadow in roentgen films, and the bronchus from which it develops is like a stalk, capped by the carcinoma tissues. Necrosis in the tumor with erosion of blood vessels causes hemorrhages. Hilar carcinomas generally are limited in size from one to several centimeters. They are gray, firm or soft, depending upon the proportions of stroma and epithelium involved. Firm tumors have marginal fibrous radiations into the parenchyma. The lumen of the bronchus is narrowed by extensions of tumor tissues or the

*From the Henry Baird Favill Laboratory, Presbyterian-St. Luke's Hospital, Chicago.

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thickening of the wall. Longitudinal folds and grooves of the lining are replaced by granular or nodular tissues.

Small bronchogenic carcinomas are warty thickenings or scarcely elevated tissues of the lining; yet they invade the lymph channels of the lungs and produce extensive metastases to the pleura and other viscera, the bones, and brain. Pleura metastases form many gray fibrous plaques, a condition years ago named "multiple endotheliomas of the pleura" because the primary carcinoma was overlooked. When a carcinoma arises from epithelial tissues deep in the wall of a bronchus, the lining may have no grossly detectable change; but the walls of the bronchioles are diffusely thickened and histological examinations disclose an extensive invasion of the peribronchial lymph channels.

Carcinoma cells grown into the pulmonary artery can produce multiple embolic metastases in one or both lungs, a form of focal pulmonary adenomatosis. Small polypoid carcinomas in the parenchyma of the lung neither cast shadows in roentgen films nor cause changes detectable by physical examination; their metastases may produce bizarre focal symptoms in other tissues of the body and systemic reactions.

Hilar carcinomas spread into the mediastinum, compress the pulmonary blood vessels, encroach upon the heart, and even erode the esophagus. Compression of the pulmonary artery or veins impedes circulation of blood in the lungs and seems to be the main cause for the dyspnea of some patients with lung carcinoma.

Invasion of the lymph channels and of the blood vessels in the lungs permits widespread dissemination of the tumor into many body tissues. These secondary growths can cause symptoms that dominate the illness of the patient; those associated with the primary tumor in the lung remain insignificant. The bizarre clinical symptoms in these patients present an enigmatic disease. Should a metastatic growth, approachable by biopsy procedures, be discovered and examined during the life of a patient, a clue of the nature of the disease is obtained. Otherwise, the bronchogenic carcinoma is revealed only by a thorough postmortem examination.

Diagnosis of carcinoma of the lung in final analysis is by the microscopic examination of tissues obtained as a biopsy or of tissues removed by surgical excision. The usual biopsy tissues



Figure 1. Granular surface of a small hilar carcinoma of the upper lobe bronchus.



Figure 2. A carcinoma near the hilus of the lung associated with necrosis of the regional peripheral tissues of the lung.



Figure 3. A bulky carcinoma of the lung.

obtained from the lungs for the detection of a cancer are bronchial secretions, including sputum, bronchial tissues, and pleural fluids. Excepting for the simple collection of sputum, the samples for examination are obtained by surgical procedures. The secretions and biopsy tissues are taken from the air passages by the bronchologist.

The small volume of the secretions and the limited amount of the biopsy tissues removed demand modifications of the usual technics required for processing tissues in order to guard against the loss of even a small particle. In practice, occasionally, the smallest piece in the sections is the only one with the significant tissue for diagnosis. The best results in these diagnostic procedures are realized when the technics of the bronchologist are closely integrated with the processing methods required by the pathologist. Those pathologists who choose to examine secretions spread in thin films on slides and suitably stained may do so. For me, however, the following work arrangements between bronchologist and pathologist have been used with advantage for many years.

Secretions

Secretions are aspirated directly into an ordinary tapered 15 cc. glass centrifuge tube. Zenker's solution (or other fixative solution) is added to adequately fill the tube which then is closed with a rubber stopper. A strip of surgical tape bearing the name of the patient is attached, and with a requisition the tube is sent to the laboratory.

Biopsies

Particles of biopsy tissues are placed at once in a tapered 15 cc. centrifuge tube. A cubic centimeter of saline solution in its tip will aid in releasing the tissues from the instrument. The fixative solution is added, in sufficient amounts, the tube stoppered, labeled properly, and sent to the laboratory.

Zenker's solution precipitates the formed and dissolved tissue elements in the secretions and promptly fixes the biopsy tissue particles. After two to four hours, the precipitates or tissues are collected by centrifugation in the tip of the tube and the fixative is decanted. The entire process of dehydration, clearing, and paraffin embedding is carried out in the original centrifuge tube. After each change of water (for washing), 70% alcohol, 80% alcohol, 95% alcohol, two changes of absolute alcohol, two changes of xylol or toluol, the secretion precipitates or tissues are collected in the tip portion of the tube by centrifugation and the solutions are decanted. Finally, melted paraffin is added to the tube, and the infiltration of precipitates and tissues with paraffin is carried out by placing the tube and its contents in a paraffin oven. Two changes of paraffin suffice. A short piece of flexible copper wire with a loop at the end reaching



Figure 4. A pseudopneumonia form of lung carcinoma,

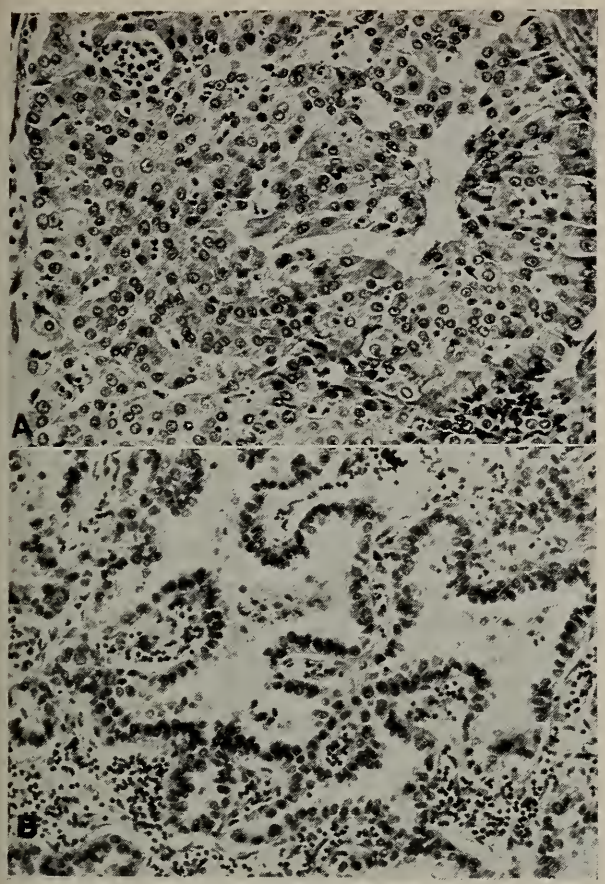


Figure 5. Photomicrographs illustrating (A) mosaics of pavement-like carcinoma cells described as squamous or epidermoid and (B) an alveolar form with a columnar cell lining.

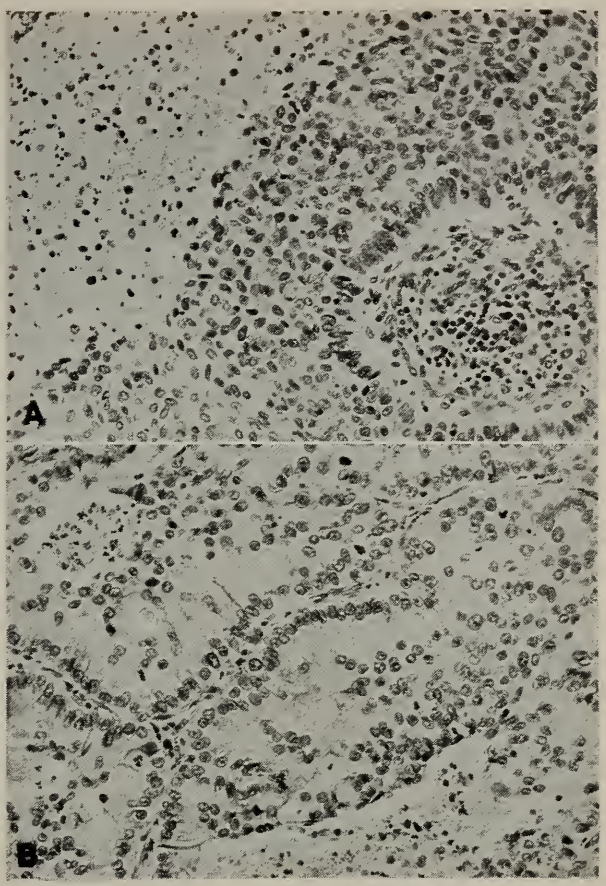


Figure 6. Photomicrographs illustrating (A) mosaics of carcinoma cells around a core of vascular fibrous tissue, and (B) cords of columnar cells with a scanty supporting stroma.

into the melted paraffin is hung over the lip of the centrifuge tube, and the tube cooled to harden the paraffin. Then the tube is dipped quickly into warm water and by means of the wire, the column of paraffin is drawn from it. The short button of infiltrated tissues at the tip is cut off and embedded in melted paraffin, cooled, and blocked for sectioning.

The sections are cut serially, enough to cover at least five slides, stained with hematoxylin and eosin, and mounted for miscroscopic examination.

In this way, all of the secretion precipitates and the biopsy tissues are conserved.

Pleural and other fluids

The sediment obtained by centrifugation of pleural or other fluids and collected in a 15 cc. tapered centrifuge tube is fixed with Zenker's solution, and the precipitate is processed in the tube as already described. Sufficient amounts of a fluid, 250 cc. if necessary and possible, should be used to obtain an adequate sample,

Cell forms

The histologic structure of bronchogenic carcinomas ranges widely. Many have pavement-like cells arranged in mosaics and described as squamous or epidermoid. The cells simulate those of a squamous epithelial mucosa. Accordingly, some tumors have large pavement cells with hornification and even pearl formation; others have smaller cells without hornification, and still others have cells corresponding in size to the deeper layers of a mucosal surface. The amount of supporting fibrillar stroma with inflammatory exudates varies; the scirrhus tumors have considerable, the medullary have less. Another group of carcinomas has small cells that resemble those in the deeper portions of the pseudostratified lining of a bronchiole. They have a scanty or a more abundant basophilic granular cytoplasm and a vesicular nucleus with several coarse chromatin granules. The supporting stroma in these cellular tissues is small in amount. The small cells resemble lymphocytes

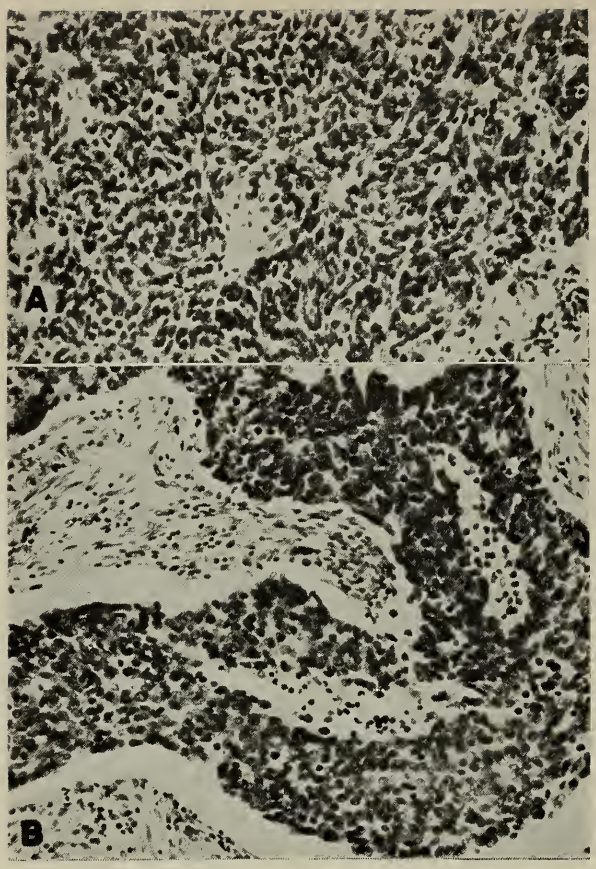


Figure 7. Photomicrographs of (A) small cell structure and (B) a larger cell form of lung carcinomas.

and sometimes because of growth conditions they are elongated and are designated as "oat cells."

Some carcinomas have cells arranged in tubules or acini; others are papillary. Occasionally the tumor has masses of "signet" cells, characteristics that indicate an origin in mucus-secreting epithelium. A few tumors have small cells repeating the structure of those lining crypts in the wall of the main bronchus. Other transitions in cell form complicate attempts to classify in detail some of these carcinomas on the basis of their histologic structure.

Despite the advances made through the technics of bronchology in the diagnosis of bronchogenic carcinoma, tissues of some carcinomas and other tumors of the lung are not obtainable through aspiration of secretions or biopsy material. The clinician then relies on his experience, the clinical data of his patient, roentgen films and even surgical exploration. The latter procedure introduces another source of tissues for examination, many of them submitted for immediate diagnosis in sections prepared by the freezing method. Some of these operations are originally intended to be or later become extensive procedures. The diseased tissues removed do not always have carcinoma, but may be the chronic granulomas of tuberculosis, blastomycosis, and histoplasmosis; other specific and non-specific inflammations; infarcts of the lung; benign tumors; metastatic carcinoma or sarcoma; lymphosarcomas and other sarcomas. Other tumors of the bronchus or lung appearing in biopsy tissues are the cylindroma and adenoma, and forms of so-called pulmonary adenomatosis (carcinoma).

Importance of pathologist's role

These comments emphasize that the pathologist requires a large general experience in tissue pathology when confronted with biopsies of the lung that may contain carcinoma. The bronchologist, probably more than any other specialist, depends upon the technical services and the professional skill of the pathologist in the practice of his specialty. He and the pathologist constitute a team in medical practice which today is required to evaluate and specifically diagnose lung disorders that may be carcinoma. The important goal is to diagnose cancer before it goes beyond the curative stage.

Cancer of the lung now leads all other cancers as a cause of death in men. The American Cancer Society, in its report of 1960, has accepted the evidence that cigarette smoking is a causative factor in lung cancer and has adopted measures to inform the public of the hazards of this habit. Preventive medicine is always more desirous and effective than is the therapeutic.

Subphrenic Abscess

Clinical-Surgical Conference

Department of Surgery, Cook County Hospital

Moderator:
Robert J. Baker, M.D.
Associate Director, Department of Surgical Education, Cook County Hospital

Discussants:
Manuel E. Lichtenstein, M.D.
Associate Professor of Surgery, Northwestern University Medical School; Chairman, Department of Surgery, Cook County Hospital; Professor of Surgery, Cook County Graduate School

Robert Jensik, M.D.
Clinical Associate Professor of Surgery, University of Illinois College of Medicine; Attending Surgeon, Presbyterian-St. Luke's Hospital

Dr. Robert Baker: The patient who presents a picture of acute or chronic toxicity and sepsis following either an abdominal catastrophe or elective upper abdominal surgery may have a complication dreaded by all surgeons. The diagnosis of subphrenic abscess demands an astute clinician with a high index of suspicion directed toward this site for early discovery and effective management.

Unfortunately, this complication is often unrecognized for some time, and, more unfortunately, it may prove fatal. Type and timing of treatment requires judgment and experience, and we are happy to have two discussants eminently qualified in both spheres.

Dr. Manuel E. Lichtenstein is from Cook County Hospital and Northwestern Medical School; our guest is Dr. Robert Jensik of the University of Illinois College of Medicine and Presbyterian-St. Luke's Hospital. We are delighted to have the benefit of their opinions in the management of this perplexing problem.

Case 1

Dr. Cooksey, surgical resident: A 45 year old white male was admitted to the surgical service of Cook County Hospital with a 48-hour history of abdominal pain, generalized, of sudden onset, and severe enough to "double him up." This pain was constant and progressive. He had had a history of heavy ethanol intake for several years, with "some stomach trouble" accompanying these bouts.

On admission, his blood pressure was 60/40 mm. Hg, pulse rate 140 per minute, temperature 101°F. rectally. He was cold, clammy, and in clinical shock. His abdomen was boardlike with no bowel sounds, and was extremely distended. Hematocrit was 55%; specific gravity of the urine 1.032. Roentgenograms of the chest and abdomen showed a large amount of free air under both diaphragms (fig. 1).

After preparation with plasma, fluids, and antibiotics, the abdomen was opened under local anesthesia and a perforated duodenal ulcer was closed. About 2½ liters of bile-stained fluid was aspirated from all quadrants of the abdomen, and the patient left the operating room in fair condition.



Figure 1. Massive pneumoperitoneum in 45 year old man with perforated duodenal ulcer and pelvic abscess.

Postoperatively a wound infection that developed was drained. Considerable subcutaneous emphysema was noted in the area of the incision, though the incision was not red nor particularly tender. The patient had a very stormy course marked by irregular temperature spikes, intermittent ileus, and drainage of a pelvic abscess. Cultures of both pelvic abscess and wound yielded *Diplococcus pneumoniae*. The patient did fairly well until the thirty-third postoperative day when he suddenly became very dyspneic, orthopneic, and began to cough up large quantities of creamy, purulent material with a slate gray color.

Dr. Baker: This patient presented himself in a critical state with a perforated peptic ulcer, which was closed and the abdomen drained. Postoperatively the patient accumulated pus in the pelvis, and probably elsewhere. He seemed to be doing well and *x*-rays were obtained, which we will see now.

Dr. William Meszaros: The first film was taken 10 days postoperatively. There is some haziness throughout the entire abdomen, and large loops of dilated small bowel are seen in the left upper quadrant. Whether this represents incomplete small bowel obstruction or paralytic ileus would be hard to say, but I would suspect paralytic ileus secondary to some abscess in the left upper quadrant, although we do not see a fluid level.

In this film (fig. 2), there is a fluid level in the left upper quadrant which could be a gastric air bubble or an abscess containing gas. Both costophrenic angles contain fluid. This was taken 12 days postoperatively and 2 days after the pelvic abscess was drained. The major fissure in the right lung field, interestingly enough, is accentuated by fluid collected there. On a left lateral view of the chest (fig 3), we see the air-fluid level more distinctly.

This film (fig. 4) is a right lateral decubitus and makes the diagnosis certain. An air-fluid level in the left upper quadrant, separate from the stomach, is seen well in this projection. There is, then, a subphrenic abscess in the left upper quadrant.

Dr. Baker: This patient was known to have a left subphrenic abscess, but he was doing very well. He had just had drainage of the pelvic abscess, and it was felt that we could temporize to see how he got along, hoping as we were for



Figure 2. Upright PA chest film, taken 10 days postoperatively. A widened major fissure in the right lung field is noted.

spontaneous remission. However, he did not allow us to wait long. He became cyanotic and coughed up large quantities of the same kind of material as had been obtained from the pelvic abscess.

Dr. Jensik, the patient at this stage of his illness presented primarily pulmonary symptoms. We would appreciate your views on the problem as now manifested.

Dr. Jensik: As a consultant would say, the history and physical have been reviewed. This patient had a serious thoracic complication, and it seemed that he solved it himself by spontaneous drainage.

Going back into the case from the etiologic aspects, there is no question that the field was ripe for the development of this subphrenic abscess. He had a perforated ulcer with a draining wound and subsequent pelvis abscess drainage. The problem of a chest complication is unusual, because at no time on x-ray was there evidence of an effusion of consequence. Of all of the complications of subphrenic abscess, the most common is pleural effusion. This is understandable because the lymphatics supplying the dia-

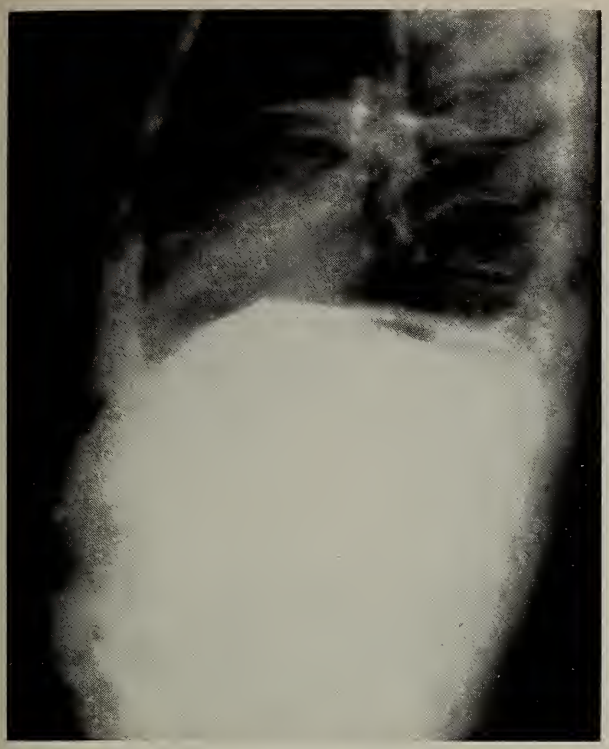


Figure 3. Left lateral chest film, showing posterior airfluid level below the diaphragm.

phragm drain upward, so that at least *half* of the cases will have pleural effusion. Whether this effusion goes on to suppuration depends on how virulent the infection is, and how massive.

In this patient we cannot demonstrate significant effusion, and this brings up the question of emphysema that was mentioned. We are told that when the wound was drained, there was considerable subcutaneous emphysema. This bothered me from the standpoint of whether it was a hallmark of the type of organism that is producing the clinical picture here.

The second thing I wondered about is, does he have an old obliterative pleuritic process making his lung adherent to the diaphragm? Was there enough erosion so that there was beginning inflammatory and destructive processes on the posterior surface of the diaphragm, and consequently air found its way to the subcutaneous tissue in that fashion? Then did a large defect develop so that he evacuated the entire abscess through the tract? The most disturbing thing is the large major fissure on the right side which makes you think of a right air pocket or collection of fluid. Was that just fluid in the right pleural space?

Dr. Meszaros: There were good lung markings. A chest film taken later makes it clearer, for, at that time, the interlobular process is gone. He did have some fluid in the costophrenic sinuses, however.

Dr. Jensik: Even at this time it is remarkable that he has so little reaction. There is no large accumulation of fluid, and I think he must have had enough sealing of the diaphragm and lung to maintain a synechia so that he just evacuated the abscess into a bronchus. That is unusual because whenever we have seen patients with subphrenic abscess, it is the pleural component that is outstanding. The thing that causes concern is whether this is pus or inflammatory effusion in the pleural space above the left diaphragm. What we want to know at the present time is how much the patient coughs, how much he expectorates, and does the bronchoscopic examination show all this coming from the left side? Did he have Lipiodol® or contrast study to show structures of the bronchial tree?

Dr. Baker: His cough subsided completely in about two days, and he now expectorates almost nothing. He has been too ill for bronchograms so far.

Dr. Jensik: Now I would like to say something about differential diagnosis. When you see



Figure 4. Right lateral decubitus film (with the right side down) showing classical air-fluid level of subphrenic abscess.

a patient who coughs up all this purulent material, you must think, first, of abscess in the lung. This is, possibly, an embolic phenomenon. He had reason enough for that, if you postulate a septie embolus to the lung which broke down and caused suppuration. Here we have not had an actual solitary mass with liquefaction and abscess formation. Secondly, one must think of empyema with bronchopleural fistula, but there is little evidence of empyema on x-ray. Then, one must think of bronchiectasis, but ordinarily that has a longer duration of symptomatology and seldom the sudden massive evacuation seen here.

Dr. Baker: This patient was in dire straits. He was taken to the operating room and bronchoscoped. Copious quantities of material were evacuated from the tracheobronchial tree, perhaps somewhat more from the left side. He was then placed on the operating table and a left lateral subcostal incision was made beeause he had a mass palpable in the left upper quadrant. From the abscess, which was on the left, both subdiaphragmatic and subhepatic, 1000 cc. of purulent material was obtained which was identical to that he had been expectorating. Penrose drains were placed into the abseess eavity, and the patient improved overnight.

Two days after drainage he was vastly improved, and we tried to demonstrate the fistulous tract with Lipiodol introduced into the drain site in the left upper quadrant, but neither dye nor saline could be introduced into it. We think the fistula is probably closing, or has already closed. The patient was very ill, but his improvement has been gradual and impressive. The first drainage site was in the left lower quadrant and is still not eompletely closed. Incision for the abscess was made over the area of presentation of the mass. A chest x-ray was obtained yesterday and was completely unremarkable.

Dr. Manual E. Lichtenstein: There are some interesting points to be made about this case. One of the cliehes we hear is that if a patient comes in 24 hours, or later, after perforation of an ulcer, he should not be operated on. Another eliehe is, if a patient comes in with acute panereatatis he does not need an operation. Sometimes these two statements may be true, but they do not hold for all patients in either category. The patient whose ulcer perforates and who is hospitalized after 24 hours is not operated on if it can be demonstrated that the perforation has already sealed over, the presumption being that if you open the abdomen you will not find the site of perforation. To find that opening, you would have to remove the plastic exudate that had formed and then put in sutures to simulate the exudate that had already sealed the hole. But what about the patient whose ulcer has perforated and who has boardlike rigidity, in whom there is no improvement, and in whom the abdominal distention becomes greater? This individual may have a low blood pressure, rapid pulse, elevated temperature, infection, marked dehydration, with specific gravity of the urine of 1.032, and a large amount of air in the peritoneal cavity. He needs to have this material evacuated. It was demonstrated at this institution that when a patient perforates an ulcer and is operated on within 6 to 8 hours, cultures of the peritoneal content are usually sterile; however, after 24 hours many organisms are present in the peritoneal cavity, and the patient needs drainage.

There is another cliche: The treatment of peritonitis is removal of the focus or closure of the leak. That eovers perforation and infection, like acute appendicitis; but what about the patient whose perforation is not leaking? He must have drainage of all of this septic material established lest it infeet in local areas as it did here. When I was a medical student at Rush Medical College, Dr. Ernest Bevan used to speak on this very subject, and he did this: He opened the abdomen, closed the perforation, placed a drain suprapubically and poured large quantities of saline solution into the peritoneal cavity to wash out the peritoneal eontent, and it would flow down into the pelvis and then be sucked out. The drain stayed in until the rest of the wound was closed. In this manner he was able to reduce the incidence of subphrenic abseess, and he already had drainage of the pelvic abseess. All this was accomplished in the days before antibiotics, and before blood banks and plasma. Blood transfusions were hard to obtain, and eross matching was not perfected; but good results were still obtainable. We must remember, however, that the mortality rate in perforated ulcers after 24 hours was very high, and washing out the peritoneal cavity was a useful procedure.

I would compliment the staff who worked on this patient inasmueh as he was not taken directly, in his state of shock, to the operating room

to have a long incision made to explore for the trouble. He had a small incision directly over the most likely site of perforation, which was found and closed. He had a long period of preparation with plasma and fluids to make it possible for him to survive even the minor operative trauma necessary to close the hole.

No drains were put in this abdominal cavity, but here is a case where you have a lot of fluid free-wheeling in the peritoneal cavity; it is 48 hours old and it can be assumed to be infected. It is not likely that a large dose of any antibiotic can sterilize that rapidly. It might have been a good thing to drain the suprapubic space or pelvis by putting in a tube and sucking out the material; it also would have been helpful to put in a Chaffin tube and aspirate the material, maintaining continuous suction to get rid of the bulk of the septic material which subsequently was responsible for the difficulty he had.

Dr. Baker: Dr. Jensik, do you think the reverse of this situation ever occurs, that is, does empyema lead to subphrenic abscess?

Dr. Jensik: It has been reported, but I have not seen this, that is, empyema penetrating the diaphragm. In empyema, usually the pus breaks through into the lung; this is the commonest and easiest direction for it to take. It is interesting to me to see this normal looking chest on the subsequent x-ray film. I would like to see bronchograms to determine whether or not there is a residual change, but I think he could have a normal bronchial tree on the left side and may not require anything more than healing of his abdominal wound.

Dr. Baker: Serous effusion as seen here is a consequence of the lymphatics carrying the infection into the subpleural area from the subphrenic space. That must ordinarily be a unidirectional route of spread.

Dr. Jensik: This spread probably could be both ways, but it is more commonly seen going upward than downward. Perhaps five per cent of infections go downward below the diaphragm from the pleural space (empyema), but it is much commoner to see the reverse.

Dr. Baker: There was some discussion about draining him posteriorly through the bed of the twelfth rib, the Ochsner route. Suppose that in draining an abscess you inadvertently entered the pleural space; what would be your management in such a case?

Dr. Jensik: If it is unavoidable, you would have to try to suture the pleura to the diaphragm to wall off that entrance. It would be very wise also to insert a transpleural catheter and maintain closed drainage in addition to having drainage of the abscess pocket. Then, in case there has been infection of the pleural space, it is closed around the catheter, and can drain.

Dr. Robert J. Freeark, director of surgical education: Suppose you have a patient about 7 days postoperative who has severe contamination and a stormy course, and who has a clouded left or right costophrenic space, is running a temperature, has some chest findings, and it isn't known whether the density in that area is left lower lobe pneumonia, or effusion, or abscess and effusion. How about needle aspiration for purposes of diagnosis—desirable or hazardous?

Dr. Jensik: This is a real enigma — trying to make a decision as to the alternatives. I don't hesitate to use a needle, but I am very cautious. I insist that the aspiration be high to determine whether the pleural component of this inflammatory process is actually effusion or pyogenic material. If aspiration is done low, you may go right through the diaphragm; and if there is an abscess, you may enter it; then, when you withdraw the needle, there is contamination, during which you may spread the process from below the diaphragm to the pleural space. I would use the needle only to determine whether there has been a change, or formation of pus in the pleural cavity.

Question: Do you feel that in exploration, after finding and closing the perforation, washing the abdominal cavity with antibiotics has any place?

Dr. Lichtenstein: This is not a question that is *de novo*. They have been pouring things into the abdominal cavity for years. In earlier days when an appendectomy was completed, we poured sulfa powder into the peritoneal cavity; later, we had patients with intestinal obstruction, and the site of obstruction was where the sulfa crystals had matted together. Next, they put soluble agents in the peritoneal cavity, fluids were poured in from the peritoneum, and still the concentration was below the level of the therapeutic dose. The fact is that the mechanical cleansing is the basis for preventing infection.

I would not say that every patient who has a perforation should have irrigations done, but

that is the difficulty in considering such a problem. If an author mentions that such and such a type of treatment should be used in a particular case, someone is liable to read or hear only part of the sentence and he will say, for instance, that the County Hospital recommends that in every case this treatment should be used. But it is not recommended in every case; it is recommended now in the case that is more than 18 to 24 hours old where there has been no sealing off of the perforation. Most of such patients probably don't have to be operated on because the leak has already been sealed, and you are waiting for an abscess to develop. Antibiotics have done the most good in such cases because they can prevent development of an abscess. They have decreased the amount of surgery necessary in this condition; it is only in particular cases that you irrigate out this fluid as you would irrigate out a contaminated wound, and then leave Chaffin tubes as drains where you expect collections of fluid. I would give all the antibiotics intravenously or intramuscularly so that the circulation would be saturated, and there would be no chance of getting septic or embolic phenomena.

Question: What about the case that is less than 24 hours old and the patient has eaten a large meal and has massive spillage for a time?

Dr. Lichtenstein: You can irrigate that abdomen too, but usually healing has begun. How large is this hole, as a rule? Soup would come out of it, of course, but spinach would plug it up. The extravasated material is sterile, and, if you operate on this patient within six to eight hours, it is not necessary to irrigate. You can aspirate the fluid that is present, but when large quantities have come out or a long enough period of time has elapsed not only to permit the materials from the stomach to leak out but for the bacteria to grow, those patients need your extra attention.

Dr. Baker: This patient had a large air-fluid level which was more posterior than anterior and yet his mass was anterior. It was one large abscess, despite the location of the air-fluid level.

Dr. Leo Zimmerman: There is only one subphrenic space on the left side and two spaces on the right. If the mass pointed posteriorly I would drain it posteriorly. If it were a smaller abscess and I did not know where it was, I would have gone in anteriorly; but always remember there is only one subphrenic space on the left side.

Dr. Freeark: Would you place the drain where it pointed?

Dr. Zimmmerman: Yes. Place the drain where the pus is.

Case 2

Dr. Marvin Tiesenga, surgical resident: This patient was a 22 year old Negro male admitted to the surgical service of the Cook County Hospital with a gunshot wound of the abdomen inflicted four hours prior to admission. The wound of entrance was located in the right upper quadrant just below the costal margin, but no exit wound was visible. His pulse and blood pressure were stable, and the abdomen was tender but not rigid. Roentgenograms disclosed the projectile at the level of the body of L-5 and a fractured left transverse process of L-4.

The patient was explored through a right paramedian incision. A through-and-through wound of the right lobe of the liver was seen, the projectile's path having continued caudally just below the inferior pole of the right kidney. No other vital structures were injured. Gelfoam® was placed over the holes in the liver and the wound was closed with drainage, using four Penrose drains into Morrison's pouch. Drainage was minimal and all drains were accidentally removed on the fourth postoperative day. The patient daily continued to spike a temperature to almost 102°F. rectally, and his progress was only fair. Fluoroscopy of the chest showed that both hemidiaphragms moved, the right not as much as the left. Tenderness and guarding developed in the right upper quadrant.

Dr. Baker: This patient presented a difficult problem postoperatively in that his temperature never really came down, as we would have liked it to in the face of minimal drainage. The drains had been removed, unfortunately, on the fourth day, and on the sixth day he had severe pain in the right upper quadrant lateral to the incision with some tenderness and fever. X-rays were taken which Dr. Meszaros will discuss.

Dr. Meszaros: On this film taken seven days postoperatively, you can see the haziness in the right upper quadrant (fig. 5). It brings up the point that you do not always have air-fluid levels in subphrenic abscess. I think we see some extrinsic pressure on the bowel in the left abdomen, which probably means that a mass is present. Chest films show no pleural reaction (fig. 6).



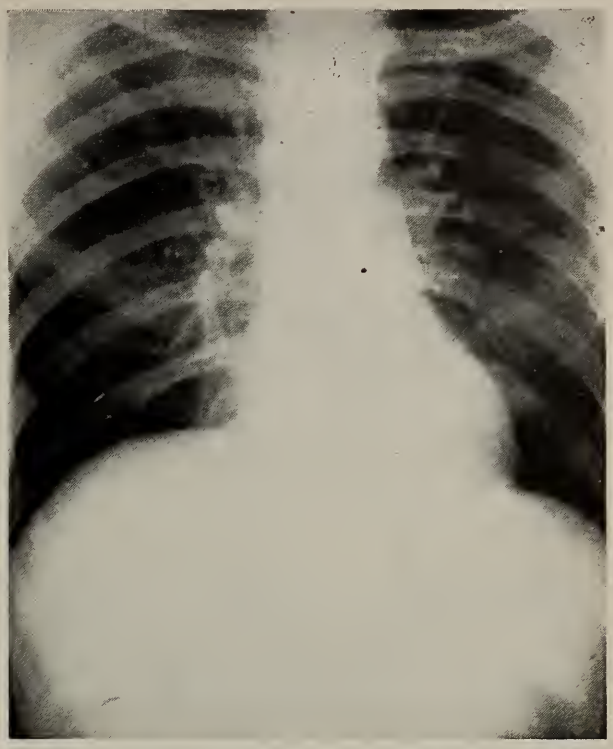


Figure 5. Upright film of the abdomen, showing haziness in the right upper quadrant. The arrow indicates compression of the gas pattern by extrinsic pressure. Figure 6. Normal chest film above.

Dr. Baker: This chest film was taken at the time the patient was tender and had fever. The purpose of the film was to attempt to demonstrate elevation or fixation or pleural reaction, which was not present. Fluoroscopic examination showed that the diaphragms moved well.

Dr. Meszaros: You can have subphrenic abscess and have the diaphragms at a normal level, and there can be motion of the diaphragms, too. In this film (fig. 5) there is a huge mass in the right abdomen. This was taken the day he was drained.

Dr. Baker: What percentage of subphrenic abscesses have air-fluid levels?

Dr. Meszaros: I couldn't give you a specific percentage. It would depend on many things — duration, for instance, and nature of the infecting organism.

Dr. Baker: I think more abscesses occur without it than with it, which is contrary to the usual thought.

Dr. Jensik: I think there are more without an air-fluid level, too. The presence of an air-fluid level makes the diagnosis relatively easy, but normally this is not the case.

Dr. Baker: This patient developed guarding and tenderness, and with this there was the radiodensity in the right upper quadrant. We felt there was suppuration in the right upper quadrant, but we questioned whether it was subphrenic or subhepatic, or within the liver substance. What would be your approach?

Dr. Lichtenstein: I notice that four drains were put in Morrison's pouch. Where was their exit?

Dr. Baker: From a stab wound in the right flank.

Dr. Lichtenstein: The radiologist pointed out this large mass. There must have been bulging on the right side, and on suspicion alone I would make the incision there. A hole had been made to do a certain thing and it was not successful. If you put a drain in Morrison's pouch, remember that the pouch is an excavation. It can hold a tremendous quantity of fluid, and it can overflow onto the superior surface of the liver and form a subphrenic accumulation. The purpose of putting in a drain is to establish an exit for something that might accumulate.

When you see a patient with injury to the liver there may be no bleeding, because some of the blood clots that have formed have already

closed the hole, but with recovery of the patient there will be bleeding. When you have a through and through hole in the liver, bile will leak out; and that presents a somewhat different problem. When an injury to the liver is sustained, necrosis will result which is not visible at the time of operation but which will occur within the next 4 to 10 days or even two weeks, and all of this material will then leak out of the damaged liver. You put drains in so there will be an open door to allow the material to come out whenever it is ready to do so. When you put drains in, leave them in. Don't take them out until they fall out or until you discharge the patient and can remove all of the sutures. Leave them in until you are sure there is nothing more to drain; one or two days' drainage is seldom sufficient because it takes some time for the material to come up.

The drain you put in went down through a stab wound into the bottom of Morrison's pouch. Drainage is usually dependent, but the Penrose drain allows for only overflow drainage. You have to have enough fluid to come up to the surface of the body and then it overflows, but it takes some time for that to occur. Stab wound sites for the drains are best, as postoperative herniation rarely occurs in stab wounds. If the drains had been left in here, possibly this complication of subphrenic abscess would not have occurred. In the last analysis, the drains here did not serve their purpose, and drainage had to be performed. You had to open the right upper quadrant, put in a Chaffin tube, suck out the fluid, and that allowed the patient to recover.

With regard to the right subcostal incision, remember that besides providing for drainage of Morrison's pouch, you want to make the incision low enough to slip a catheter behind the liver in the posterior subphrenic space and above the liver into the anterior subphrenic space; then you can empty out the liquid contents of those spaces very rapidly and allow the walls of the cavity to coalesce. They will plaster over if you can keep the spaces empty. That is part of the difficulty inherent in use of the Penrose drain, as it is only a means of keeping the wound open for overflow. If the accumulation of fluid is large, never depend on the Penrose to decompress the space. You must enlarge the incision and put in a stiff rubber tube or a tube through which suction can be applied to empty out the contents. In some patients, infection is not the problem as it was in these cases, but rather extravasation of fluid, such as bile, duodenal contents, etc.

A case in point is that of a patient who had a cholecystectomy, and no drains were used. It was an "easy case." The gallbladder came out, everything was dry, the wound closed without drainage, and on the third postoperative day the patient had difficulty breathing, respirations were rapid, and the temperature was elevated. When an x-ray was taken, the diagnosis of pleurisy was made because of a pleural effusion, and she was treated for the respiratory condition. They inserted a needle to aspirate the fluid and obtained about 1000 cc. of golden yellow bile. The "effusion" was the diaphragm pushed high into the right hemithorax. There was no air-fluid level, and sterile fluid was obtained. It was not an abscess, nor was it a hematoma, but just pure bile that accumulated below the markedly elevated diaphragm.

It is important to scrutinize the x-ray film carefully because the rounded area must be identified as diaphragm. If a needle is put into the pleural cavity to aspirate the fluid, an empyema will result from contamination of the pleural space. Fortunately, in the case I cited, there was sterile bile and no infection took place. Even though the case looks easy, it is possible that damage can occur, and I think all cholecystectomies should be drained.

I should like to reiterate: When a drain is put in, just leave it in. Don't take it out too soon. There is no point in taking the drains out before you take the sutures out, and in subphrenic accumulations I would leave the drain in as long as material is there and draining.

Dr. Baker: This patient had a large accumulation of purulent material in the right subhepatic space, and this was drained through a right subcostal incision. A tube was inserted and suction was started. I think the point is well taken that a Penrose drain is not the same nor as effective as stiff catheter drainage.

Dr. Freeark: Dr. Jensik, have you seen biliary fistula into the chest?

Dr. Jensik: No, I have not seen any, but several cases have been reported.

Dr. Baker: We were confused here because there was such a large abscess, and yet the diaphragm moved so well. But it was the subhepatic and not subphrenic location which allowed

this to occur. Ordinarily a collection between the liver and diaphragm will paralyze diaphragmatic activity; when the liver is interposed between the pus and the diaphragm, this is much less likely to occur.

Summary and conclusions

1. The most common causes of subdiaphragmatic abscess in any of the six spaces are perforated peptic ulcer and then appendicitis. Together they represent about 50 per cent of all cases of subphrenic accumulations of pus.

2. Abdominal operations, such as cholecystectomy, splenectomy, and subtotal gastric resection, may be the prelude to a life endangering intra-abdominal abscess.

3. About one half of subphrenic abscesses are pure culture infections involving *E. coli* or a streptococcus; less commonly, staphylococcus. Mixed infections comprise the other half of the group, and *E. coli* is almost always involved.

4. The recumbent position, during bedrest or following abdominal surgery, allows the region of the junction of diaphragm and posterior abdominal wall to be dependent; fluid and/or pus gravitates to this position, and is spread over the diaphragm and adjacent viscera by constant movement. Fowler's position, in which the patient is kept semi-sitting, is designed to prevent this gravitation of fluid and pus, permitting it to run into the pelvis for easier evacuation.

5. Diagnosis of subphrenic abscess is usually based on several of the following signs:

a. Persistent sepsis, with or without fever
b. Chills, tachycardia
c. Upper abdominal pain, shoulder pain
d. Persistent, localized tenderness in an upper quadrant or over the costal margin.
e. Vomiting, distention
f. Anemia, leucocytosis (usually polymorphonuclear)

6. X-ray examination is helpful in assessing the subdiaphragmatic spaces. The most useful films are upright PA and lateral films of chest and upper abdomen; fluoroscopy as well should be used. The salient findings on x-ray and fluoroscopy in the presence of subdiaphragmatic abscess are

a. Elevation of the affected hemidiaphragm
b. Diminution or abolition of movements of the diaphragm on the affected side
c. Increased thickness of the diaphragm, and loss of sharp definition of the upper border
d. Pleural effusion, basal pneumonitis, or basal atelectasis
e. Presence of gas in a subphrenic abscess
f. Large subphrenic radiodensity

Use of diagnostic pneumoperitoneum to delineate subtle abscesses has been of great value in some cases.

7. Serous pleural effusion is a common occurrence in subphrenic infection. Its recognition in a patient who has had an abdominal operation or catastrophe should always lead to the search for a subphrenic accumulation of pus. This fluid may be clear or somewhat cloudy, rarely contains microorganisms, contains protein, and frequently red and/or white blood cells.

8. The three most important causes of intrathoracic suppuration in association with subdiaphragmatic abscess are

a. Rupture of the abscess through the diaphragm
b. Inadvertent transthoracic drainage of the abscess
c. Penetrating thoracoabdominal wounds resulting in suppuration

9. Bronchial fistula is sometimes a complication of the abscess, usually the consequence of the lung becoming adherent to the diaphragmatic pleura prior to the abscess rupturing through the diaphragm.

A Universal Gonadal Shield

Enrique Schwarz, M.D., John I. Pretto, M.D., and Samuel Martin, R.T., *Chicago.*

In recent literature, in both medical and lay publications, much has been written about the ultimate genetic effect on man of cumulative exposure to roentgen rays. At the same time, however, the number of diagnostic radiographs of the gonadal area is increasing without adequate patient protection. The unacknowledged need and the lack of suitable shielding devices for such radiographs is obvious.

Ardran and Kemp in 1957 employed a T-shaped lead shield for protection of the male gonads during diagnostic procedures.[1] Another testicular shield was devised by Dr. Paul Hodges in 1958, built at the University of Chicago, and used to good advantage.[2] Reported that same year, too, by Abram et al. was a simple lead shield for the protection of the female gonads.[3] Our modification of this shield has been tested and used successfully for both men and women of all ages. For us, it is the most practical mechanical solution to the problem of protection; enforcement of use is another problem.

This shield may be easily adjusted to various sized patients by simply fanning the leaves. It is shown in Fig. 1. Its use and flexibility are illustrated in Fig. 2-3.

**From the Department of Radiology, College of Medicine, University of Illinois, Chicago.*

Summary

A simple, easily constructed, inexpensive, expandable gonadal shield which can be applied to any patient of either sex in any age group is described. It is easily portable, placed, and adjusted by a technician, and affords adequate gonadal protection for most table-type diagnostic radiologic procedures.

REFERENCES

1. Ardran, G. M., and Kemp, F. H.: Protection of the Male Gonads in Diagnostic Procedures, Brit. Radiol. 30:280, 1957.
2. Hodges, P. C., Strandjord, N. M., and McCrea, A.: A Testicular Shield, J.A.M.A. 167:1239, 1958.
3. Abram, E., Wilkinson, D. M., and Hodson, C. J.: Gonadal Protection from X-Radiation for the Female, Brit. Radiol. 31:335, 1958.

Figure 1

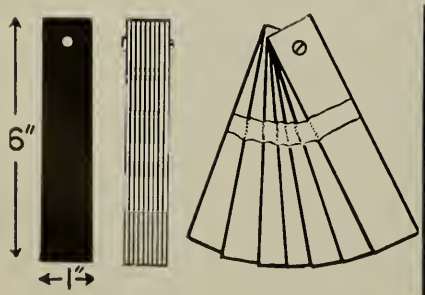


Figure 2



Figure 3



A Look at Our Future*

H. Close Hesseltine, M.D., *Chicago*

Now that the last session of House of Delegates is drawing to a close, there are matters for your future consideration that are worth stressing.

You, the members of the House of Delegates, shoulder a serious responsibility as representatives of over 10,000 members of our organization. Since you are representatives of the respective counties, you could, and should be, excellent avenues of communication also.

In the months ahead, as in the years gone by, we will have problems. We know that legislative medicine is bad medicine. We know that our efforts in the health and welfare of our people have surpassed by far those of all other groups. The history of our success in advancing and elevating standards of medical care stands out in bold relief. Since 1920 we have witnessed more advancements in medical and surgical care than occurred in all the preceding centuries. Remarkable progress has been made in the realm of infectious and metabolic diseases. Surgical skills now include procedures undreamed two score years ago. Scientific, medical, and surgical services, judged by the current times, envision an even brighter future with further extension of life, with more comforts and better health. If this progress is to be beneficial and balanced, it will require that we keep the public informed, first, for their own proper use of our services, and secondly, so that we and our abilities are not misunderstood.

The public now realizes that medical sciences not only can cure but that they can do much to prevent disease, illness, and anguish—both mental and physical. Our public relations in the past have been good but must be improved.

Today, nearly 20 per cent of a working person's adult life will be spent in retirement when enforced at the age of 65. In another few years, according to predictions, about one-fourth of his adult life will be spent in retirement unless current practices are changed.

Organized medicine is primarily responsible for this extension and for increasing the benefits of life. We have lived and practiced by the laws of God, the will of society, and the instinct of man. We have paid respect to the dignity of the individual and have supported private enterprise, and, we have championed freedoms.

Unfortunately, medical costs can be expected to increase because of the increasing costs involved in scientific progress, and the increasing demands for greater use of results of that progress. This year the public will spend more for medications, appliances, glasses, and like aids than they will pay to physicians.

We should encourage all people to anticipate their medical, social, and economic future. If one would work regularly from the age of 25 to 65 (40 years) and during this employment—either by his own efforts or jointly with his employer by some combination of percentages—would put aside 10 per cent of his yearly income, it is estimated that at a 3 per cent interest rate he would realize a life-time annuity at age 65 equal to about 50 per cent of his last year's salary. Professional people, like physicians, almost invariably start making a livelihood much later than at 25 years of age, but they tend to work beyond age 65. If the government would permit the self-employed to put aside retirement funds before taxation, we could have some of the same economic security.

The matter of "Relative Value" is still before us and will keep reappearing until some resolution of the problem is achieved. We should investigate all of the aspects of the matter thoroughly. Such systems permit adjustments readily. As a matter of fact, all fees have a relative value whether they are established on a formal or informal basis. The Relative Value system is a formal system. It is concrete. It allows better actual

**Acceptance Address of the president before the House of Delegates, 120th annual meeting, Illinois State Medical Society, May 26, 1960.*

projection. It permits modification with greater ease. It ean be adjusted to an individual's praetiee, and special factors may be added to this structure.

It is ironie that we, the medical profession, must be organized to protect the health interests of the public. Our influence would be enhanced by encouraging every qualified, eligible physician to membership and an active role in organized medicine. There are a number of physieians (not now on our membership list) on medieal school faculties, in industry, governmental agencies and like positions who could increase our membership roll to the advantage of all of us.

Whitehead warned us upon the need ". . . . for continual contemplation of greatness, lest we bog down in the quicksands of trivia." Santayana enjoined us to comprehend our place in society and the profession by knowing history, "for those unaware of history are doomed to repeat it."

We must be alert that we may reeognize the problems early, diagnose the situations with accuracy, and institute approaehes and managements for the best possible end-results. The future, according to all indications, will present to us more medico-social and medico-eeonomic problems than we have encountered in the past. If we fail to rise to the occasions as these matters appear, the public and the medical profession will both suffer—perhaps irreparably. We must not fail the public. We dare not fail.

Time for rebuttal

In the past many have eriticized these theories and the claims of zealous Freudians for the laek of scientific evidence. I cannot reeall a single rebuttal to such criticism in which the issues raised were squarely met. Instead of answers or the presentation of evidence, one is likely to reeeive a violent, and perhaps sarcastie, personal rebuke. The reaction of a prominent psychiatrist to Emil Ludwig's study of Freud and his theories is illustrative. In his review of this book the psyehiatrist avoids all of the arguments made by Lugwig and neglects all the evidenee presented. Instead of attempting a rebuttal, the reviewer confidently asserts that Ludwig's failure to accept Freudian theory is an expression of his envy and that this envy is a result of the faet that Freud was a greater biographer than Ludwig.

Tactics such as these are sometimes accompanied by an abstraetly philosophieal argument in which points are "proved" by analogy. Analogies, we all realize, are useful in the effort to express oneself; but they do not constitute evidenee—not even a little evidence! Specious evidenee is also sometimes produced by extracting from a case study the very assumptons that were plainly projected into it by the observer. Why cannot proof of these eherished beliefs be offered? Fifty or more years have passed since the basic theories were advaneed. Surely this has afforded time for some pieee of irrefultable evidence to be produeed; for something sufficient to hush mouths such as mine. If such evidence does exist, I see no reason why it should not be pointed out to me. *Corbett H. Thigpen, M.D. Multiple Personality. The New Physician. May 1960.*

Psychological factors in migraine

The third way in which psyehologieal factors seemed to act was that, in established magrainous subjects, they precipitated a series of attacks. This was more obvious among the men. One developed an exaeerbation when told his child was a mongol; another when he was rejected for the serviees; a third during a period of exeessive work for his trade union; another in relation to accountancy examination; another during his wife's pregnancy; and a ehildless woman when she lost her pet dog. One patient described it graphically: "My mother died, my daughter went to Canada, my huband lost his teeth, and my boy ehanged to ladies' hairdressing, all in month." *Richard A. Hunter, M.D., and Ian P. Ross, M.D. Psychotherapy in Migraine. Brit. Med. J. April 9, 1960.*

Skin Manifestations in Sepsis in Newborn

Julius J. Wineberg, M.D., *Waukegan

Septicemia of the newborn carries a high motality. Diagnosis is not easily made, as the newborn frequently do not react to infection with fever and toxic symptoms. Successful treatment depends on early recognition.

Skin lesions as an early sign of sepsis have been described by several clinicians. Dunham[1] reviewed 39 cases, 18 of which had skin lesions. Twelve were characterized by erysipelas or a localized abscess caused by Group A hemolytic streptococci. Fives cases of staphylococcal origin had impetigo, pemphigus, multiple abscesses, and dermatitis exfoliativa. Silverman[2] described four cases of septicemia with a skin eruption. He added sclerema and a diffuse macular eruption as an additional skin manifestation. Smith[3] and Nyhan[4] describe erysipelas, impetigo, subcutaneous abscess, and sclerma as the skin manifestations of septicemia,

The purpose of this paper is to report a transient, undescribed rash which was the initial sign of sepsis in three premature infants. During a six month period three premature infants, who were progressing well otherwise, developed a transient rash consisting of faint pink macules 5 to 10 mm. in size, discrete, and scattered over the lower abdomen. In one case the rash disappeared prior to antibiotic therapy; and in the other two cases antibiotics were prescribed at once, and the rash disappeared within 24 to 36 hours.

Blood cultures were taken at the inception of the rash, the skin having been cleaned with pHisoHex® and then treated with iodine followed by alcohol. The blood was collected in vacuum bottles, separate needles being used for penetrating the skin and the vacuum bottle.

Cultures from two different infants grew hemolytic *Staphylococcus aureus* coagulase positive within 36 hours, and Group A hemolytic streptococci were isolated from the blood of the third infant.

Case reports

Case 1. J.M., born in an automobile, was said to be of 6½ month gestation. Birth weight was 3 pounds 7 ounces. The infant was placed in an Isolette® with full humidity and was given Achromycin® for three days. Feedings were started at 48 hours of age, and the baby took 10 to 15 cc. every two hours, sucked well, and was active. The weight decreased to 3 pounds ½ ounce. At 4 days of age the infant developed some pink macules on the lower abdomen and intertrigous erythema in the groin. Cultures were taken of nose, throat, skin, and blood, even through the infant was clinically normal and no antibiotics were used.

On the fifth day the rash began to disappear, and on the sixth day was gone, but the infant suddenly turned cyanotic, refused feedings, and his condition deteriorated in spite of Chloromycetin®, erythromycin, and gamma globulin. Nose, throat, and skin cultures revealed *Staphylococcus aureus* coagulase positive. The organism was penicillin and tetracycline resistant but sensitive to Chloromycetin and erythromycin.

Comment. The baby was clinically well at the time of the inception of the rash. This was not the typical rash of sepsis, and antibiotics had been withheld.

Case 2. M.S. was born Nov. 9, 1958, one of twins of a 40 week gestation, weight 3 pounds ½ ounce. His fraternal sibling died after 48 hours from hyaline membrane disease. He was placed in an Isolette. Feedings started at 72 hours, and he took 5 to 10 cc. every two hours. The infant was active, sucking well, and maintained normal

*Victory Memorial Hospital

Dr. A. Thain referred case I and Dr. R. Robbins, case II.

color without oxygen. He received 150,000 units of penicillin for five days and ½ cc. of gamma globulin.

At 15 days of age five or six salmon-pink macular papules ½ cm. in size, discrete, round, fading on pressure, and without pus appeared on the lower abdomen. Cultures were immediately drawn, the baby placed in an isolation nursery, and Kantrex® and Chloromycetin started at once. Within 48 hours the rash disappeared, and the infant continued to appear healthy. Suddenly he began to suck poorly, developed cyanotic spells, and showed general deterioration. Cultures of the blood and throat revealed Group A hemolytic streptococci. The infant was fed by gavage, and 300,000 units of penicillin was administered daily. He had a very stormy course for one week and then made an uneventful recovery. He was discharged January 6 weighing 5 pounds.

Comment. This illustrates the presence of sepsis in an otherwise normal infant whose treatment was instituted 48 hours prior to clinical symptoms, because of the significance given a very mild rash. A delay of 48 hours in a premature infant could be fatal.

Case 3. L.D. was born Nov. 7, 1958, after a 7 month pregnancy. The infant had good color and respiration at birth, but looked very premature. She was placed in an Isolette and given ½ cc. of gamma globulin. Two days later a fine papular rash appeared on the lower abdomen. Blood, nose, and throat cultures were taken, and penicillin (150,000 units) and Chloromycetin (100 mg./Kg.) were started intramuscularly. The baby's color remained good, the cry was lusty, and she was active. The following day the rash was gone and the baby continued to do well. Glucose feedings were started.

Hemolytic *Staphylococcus aureus* coagulase positive were noted on blood culture. Throat culture revealed pneumococci, gamma streptococci, and *Staphylococcus albus.* Nose culture revealed *S. albus* and gamma streptococci. A culture from the skin grew *S. albus* and *S. aureus* (hemolytic).

On November 11 the baby became listless and began to have cyanotic spells. A venostomy was done, and fluids and erythromycin were given by vein and Kantrex, intramuscularly. The baby began to improve slightly; but on November 13 the condition deteriorated rapidly and the baby died.

Summary and conclusions

Skin manifestations consisting of petichiae, impetigo, erysipelas, sclerema, abscesses, and bullae associated with sepsis of the newborn have previously been described.

This paper describes the occurrence of a transient maculopapular rash in premature infants as an early sign of sepsis. The importance of this rash is clearly seen in case 3 when antibiotics were instituted 48 hours prior to any clinical signs of sepsis. The transient nature of the rash makes it imperative that nurses in charge of prematures report promptly to the physician in charge the presence of any rash no matter how innocuous its appearance. The organisms associated with the rashes were coagulase positive staphylococci in two cases and Group A streptococci in one case. The rash described was not characteristic of the infecting organism.

REFERENCES

1. Dunham, E. C.: Septicemia in the Newborn, Am. J. Dis. Child 45:229, 1933.
2. Silverman, Wm. A. and Homan, Wm. E.: Sepsis of Obscure Origin in the Newborn, Pediatrics 3:157, 1949.
3. Smith, R. T.; Platou, E. S., and Good, R. A.: Septicemia of the Newborn; Current Status of the Problem, Pediatrics 17:549, 1956.
4. Nyhan, W. L. and Fousek, M. D.: Septicemia of the Newborn, Pediatrics 22:268, 1958.

Cytology

The usefulness of cytology in early detection and treatment of carcinoma has been well established. To make study worthwhile and productive, the pathologist needs slides of material on which cells retain their shape and content. The College of American Pathologists and the National Cancer Institute has published the methods of slide preparation included in this Reference Sheet

Several methods can be used to collect material for cytologic examination. If any doubt exists as to how the specimen should be obtained, the pathologist to whom the specimen will be sent should be consulted. If the patient is pregnant or has received endocrine treatment or irradiation therapy, this information also should be sent to the pathologist.

Vaginal aspiration has value in detecting cancer, and is also the material of choice for an evaluation of endocrine status; cervical aspiration provides a comprehensive sampling of the most critical area in the uterine cervix. Samples of these cervical scrapings are prepared for the pathologist as follows.

Preparation of cell films.

The collected material is transferred **immediately** to a glass slide, allowing sufficient space at one end for labeling. The collected material is distributed in a thin film over the slide by means of the aspirating instrument or by transferring the material to one slide and then using the end-edge of a second clean slide to spread the material, as is sometimes done in making a blood film. Because various techniques can be used to prepare the cell films, the cytologist or pathologist to whom the specimen will be sent should be consulted as to his preference.

Fixation of cell films.

The cell films are immersed **immediately** in the fixing solution. The solution may be composed of equal parts of 95 per cent alcohol and ether, or 90 per cent isopropyl alcohol or even acetone may be used. Slides can be separated in the fixing solution by fastening a paper clip at each end. This allows the fixative to come in contact with the entire cell film and prevents the cell films from rubbing against each other. Care should be taken to insure that the level of the fixative is adequate to cover the cell films to prevent drying of the specimen.

Preparation for mailing.

The slides are fixed at least for 30 minutes. When removed, they are covered with glycerine before drying occurs. A clean glass slide can then be applied to the slide with the cellular preparation, to act as a temporary coverslip to facilitate handling. The slides are mailed preferably in cardboard mailing tubes rather than in flat containers in order to lessen the chance of breakage. A completed requisition form should accompany the slides. Without certain pertinent information, it is difficult to evaluate some cellular changes correctly.

Sputum and bronchial material; fluids from pericardial, pleural, peritoneal, or joint spaces; nipple fluid; gastric secretions; urine; and specimens from the prostate, colon, and duodenum necessitate various procedures for evaluation of the material.

Preparation of Slides



1. The material is placed on a new, clean slide . . .



2. The specimen is distributed in a thin film . . .



3. Material must not be dried before fixation . . .



4. Slides are covered with glycerine after fixing . . .



5. A clean glass slide is used as a coverslip . . .



6. Cardboard tubes are preferable for mailing . . .

Illustrations and directive paragraphs are from the brochure "The Importance of Cytology to the Practicing Physician", published and distributed by the College of American Pathologists.

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A B C

Figure 1. Case 1. Admission radiograph of abdomen (A) demonstrates marked colon dilatation. Exploratory laparotomy revealed no obstruction or volvulus. B. Barium enema examination 10 months later. Colon is essentially normal. C. Post-evacuation film shows colon not dilated nor obstructed.

Adult Megacolon without Obstruction

Myron Melamed, M.D., Anton M. Pantone, M.D., and Jack Williams, M.D.,* *Chicago*

Megacolon, without small bowel dilatation, in an adult is frequently related to mechanical obstruction. In some instances, however, massive dilatation of the colon can be related to other causes. For this reason, the presence of a dilated colon suggesting obstruction on a radiograph should not be interpreted as an obstruction without confirmatory barium enema examination.

Two cases are herein presented in which massive colon dilatation was definitely not related to blockage of the distal colon. The etiology of large bowel dilatation in these older patients was apparently due to a form of paralytic ileus or neurologic disturbance. Clinical and laboratory studies failed to determine a cause.

The first patient (Case 1), a 75 year old white male, was admitted to the hospital with abdominal pain, constipation, and abdominal distention of three days' duration. He was a known cardiac patient under digitalis control. A radiograph of the abdomen (Fig. 1A) revealed colon distention of marked degree. Diagnostic possibilities included mechanical obstruction of the left colon, cecal volvulus, or unusual paralytic ileus. Barium enema examination revealed no obstruction of the sigmoid colon or cecum. The radiographic diagnosis: unusual form of paralytic ileus. An exploratory laparotomy revealed marked dilatation of the colon with no evidence of intrinsic lesion of the large bowel, cecal volvulus, nor vascular obstruction. A cecostomy was performed and closed one month later. Barium enema examination 10 months later (Figs. 1B and 1C) showed a normal colon.

Diagnosis: Unusual form of ileus with massive colon distention. No mechanical obstruction.

Case 2 concerned a 68 year old white female admitted to the hospital with a clinical diagnosis of cerebral vascular accident with sudden onset of convulsions and a varying state of consciousness. The neurologic consultant's diagnosis was, "convulsive disordor secondary to cerebral vascular insufficiency." The patient's history was noncontributory. She had had a cholecystectomy and choledochoplasty in 1956. Shortly after admission, marked abdominal distention was noted. A radiograph disclosed marked colon distention (Fig. 2A), but barium enema examination revealed no obstruction or evidence of intrinsic

*From the departments of radiology and internal medicine, College of Medicine, University of Illinois, and Grant Hospital, Chicago.

colon disease. The patient improved with conservative management and was discharged from the hospital two weeks after admission. A radiograph of the abdomen shortly after discharge (Fig. 2B) revealed no abnormality. The bowel shadows were well within the range of normal. There was no bowel dilatation. Laboratory examinations were not contributory.

Diagnosis: Unusual form of ileus with marked colon distention. No mechanical obstruction.

The main concern in adult megacolon revolves about mechanical obstruction. However, cases of megacolon in the aged without known cause, or due to hernia with incomplete obstruction[1,2] have been described. In addition, megacolon has been described in parkinsonism and chronic avitaminosis.[4,7] Similarly one may occasionally observe colon dilatation related to pancreatitis[5] and mesenteric thrombosis. Marked dilatation of the colon has also been described in cases of ulcerative colitis[3,6] and we have observed a few such patients. The cases of colitis are easily differentiated by clinical history, proctoscopic findings, and radiographs of the abdomen with or without barium in the colon.

We believe that our patients' findings can be related to unusual forms of paralytic ileus. The possibility of "functional" disturbance producing abdominal distention with extreme degrees of megacolon should always be kept in mind.

Summary

Two cases are herein presented in which extreme degrees of colon dilatation were not relate to mechanical bowel obstruction. The described findings can be the result of an unusual form of paralytic ileus or, as in one case, to a "neurologic disturbance."

REFERENCES

1. Creech, B.: Megacolon; Report of a Case in the Aged and Review of the Literature, North Carolina M. J. **11**:241-246, 1950.
2. Drye, J., and Pirkey, E. L.: Acquired Megacolon, Southern Surg. **16**:196-203, 1950.
3. Lumb, G., Protheroe, R. H., and Ramsay, G.: Ulcerative Colitis with Dilatation of the Colon, Brit. J. Surg. **43**:182-188, 1955.
4. Lewitan, A.; Nathanson, L., and Slade, W.: Megacolon and Dilatation of the Small Bowel in Parkinsonism, Gastroenterology **17**:367-374, 1951.
5. Machela, T.: Medical Aspects of Pancreatitis, J. A. M. A. **169**:1571-1577, 1959.
6. Madison, M. S., and Bargen, J. A.: Fulminating Chronic Ulcerative Colitis with Unusual Segmental Dilatation of the Colon. Report of Case, Proc. Staff Meet. Mayo Clin. **26**:21-24, 1951.
7. Raia, A.: Pathogenesis and Treatment of Acquired Megacolon, Surg. Gynec. & Obst. **101**:69-79, 1955.

A



B



Figure 2. Case 2. Radiograph (A) disclosed marked dilatation of the colon. Differential possibilities include mechanical obstruction of left colon or unusual paralytic ileus. Barium enema revealed no obstruction. B. Radiograph 2 weeks later shows no bowel dilatation following conservative management.

Low Sodium Diet In Congestive Heart Failure*

Edith B. Farnsworth, M.D., *Chicago*

Like other branches of culture, medical thought forms traditions of considerable durability. In the context of therapeutics, concepts may exist in the absence of a well-established scientific basis, or they may precede by many years a systematic clarification of the mechanism. The administration of a "low-sodium diet" to patients in congestive heart failure is a tradition in medical practice which has added a few years to the lives of these patients; but the mechanism of this important benefit has remained incompletely elucidated, notwithstanding extensive research on the subject. Viewed as a sauce-pan, a container with a single compartment bounded by impermeable walls, the patient has been far better off when the physician limited the therapeutic seasoning; but, viewed as an aggregate of several inter-related fluid compartments bounded by permeable living membranes, such an approach may be a gross oversimplification which, commonly practiced, may tend in turn to an undesirable loss of insight on the part of the physician.

An individual ordinarily ingests 10 to 15 Gr. of sodium chloride daily. By eliminating sodium in food preparation and in prescriptions and by avoiding foods rich in sodium, the daily intake of sodium may be reduced to 500 mg. or even less on a diet otherwise nutritionally adequate.

Whether the intake includes 1 or 15 Gm. of salt, absorption from the gastrointestinal tract is practically complete, a fact deduced from the virtual absence of salt in the feces. Incorporated in the blood plasma in appropriate concentration, salt is available for distribution in the extracellular fluids, to a far lesser extent in the intracellular fluids, and in the tissue pools. Under normal conditions, about 1.4 per cent of the renally filtered salt will be continually eliminated from the body by the kidneys. Loss of salt takes place also by the lesser routes of sweat and tears.

The total body content of sodium has been estimated at about 80 mEq/Kg.[1] Since estimates are based upon dilution experiments employing tracer substances, allowance must be made for the fact that results thus obtained are based upon "exchangeable" ions, and that sodium which is somehow fixed is not taken into account, or is merely conjectured.

Redefinition of terms

Values for sodium concentration in the fluid compartments, as well as the definition of the compartments themselves, have varied according to the methods adapted for analysis. Thus, earlier work, which depended upon chemical determinations carried out upon fluids and tissues, defined the spaces as (1) blood plasma, (2) extracellular space, and (3) intracellular space, with approximate sodium concentrations of 140, 140, and 10 mEq./L., respectively.[2] Dilution studies employing various tracer elements have posed the problem from another angle, redefined the fluid compartments, and advanced another series of values, in which "space" denotes the volume in which the tracer substance is diluted.

Also the factors which guarantee the volume and composition of the fluid compartments and govern the migration of sodium from one compartment to another have undergone revision since Starling's law concerning the passage of fluids across the capillary barrier was first postulated. Developing insight into the role of hormones in the active transport of substances over membrane barriers has thrown certain doubts

**While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the author and do not necessarily represent the official view of the committee.*

upon the relative simplicity of equilibrated hydrostic and osmotic pressure operating over inert membranes.[3]

Despite these areas of imperfect scientific information, the decreased excretion of sodium and its resultant decreased ratio to chloride has been demonstrated clearly in congestive heart disease. Conversely, therapeutic effectiveness of both mineral salts containing the chloride anion and diuretics which (by whatever mechanism) are capable of reducing the tublar reabsorption of sodium is clinically obvious.

Distribution of body fluids

Let us now review the distortions of body fluid compartments and of their contained electrolyte solutions, in the syndrome of congestive failure, in order to observe in greater detail the effect of variations in the intake of sodium. In proposing such a simplified working hypothesis, it must be acknowledged that the opinion of investigators on all points is by no means unanimous.

The diagnosis of congestive heart failure is ordinarily made at the bedside, upon the detection of some or all of the classical signs and symptoms, namely, manifest edema of dependent parts, hydrothorax, rales in the lung bases, dyspnea, cyanosis, tenderness and engorgement of the liver. An increase in the volume of extracellular fluid may be inferred. Although quoted values vary somewhat, it is probable that plasma volume is also somewhat augmented. The condition of the intracellular compartment, its composition and volume, are difficult to assess reliably, although there is evidence that sodium and water are increased within, as well as outside, the cells. Determinations of serum sodium, potassium, chloride, and carbon-dioxide combining power are likely to fall within normal limits. The ratio of sodium to chloride in the urine will be found to be decreased, unless modified by the administration of exogenous mineral salts. Plasma protein concentrations are rarely diminished significantly. Venous blood pressure is characteristically elevated; and circulation times, particularly in the greater circuit, are substantially prolonged.

The fate of 5 Gm. of ingested sodium chloride may be readily predicted, despite the uncertainty which still exists concerning the mechanisms by which the changes just noted have been effected. Absorption of sodium will elicit thirst which will be satisfied by intake of water. Plasma volume will increase somewhat, concomitantly with an increase in sodium concentration. This temporary increase would normally equilibrate rapidly with the extracellular fluid across the membranes of the peripheral capillaries, and normal function of the renal tubules would operate to reject the excess of sodium and water, thus tending to preserve the total body sodium and water within normal range.

Imposed upon the pathologic modifications of fluid volumes and electrolyte concentrations already existing in congestive failure, the extra sodium charge will further increase the serum sodium concentration and the plasma volume. The capillary membranes will detect such increases and transmit them, at least partially, to the extracellular fluids. The result will be reflected in increased edema; and the augmentation of fluid in the lung bases will be noted as intensification of cyanosis and dyspnea. The increased sodium load presented by the glomeruli to the renal tubules will meet the increased reabsorption which is the characteristic dysfunction of the syndrome; and the relative oliguria, with decreased sodium-chloride ratio, will increase total body weight, on the basis of an absolute increase in body salt and water.

Effects of limiting sodium

Conversely, the limitation of sodium in the diet will promote the absorption of fluids poor in sodium and the dilution of the serum sodium concentration. Decreased concentrations at the capillary barriers will be equilibrated by the passage of sodium from the extracellular fluid back into the circulating plasma. Offered to the renal tubules, the diminished sodium load will promote a water diuresis and facilitate the excretion of sodium. Thus, the total body sodium will tend to diminish, and the signs and symptoms of congestive heart failure will be ameliorated.

If to the limitation of dietary sodium is added the administration of a diuretic which will artificially produce a sodium diuresis, cardiac compensation can usually be reestablished, at least for a period, and the fluid compartments can be restored to normal volume and composition. Diuretic agents may act to prevent the absorption of sodium from the gastrointestinal tract, as in the case of the resins; they may modify the elaboration of urine in such a way as to induce

the excretion of sodium, as in the case of mineral diuretics; or they may predispose the renal tubules against the reabsorption of sodium, as with the carbonic anhydrase inhibitors.

In conclusion, mention should be made of the possible dangers of long-continued sodium restriction, although these are surprisingly infrequent, unless vomiting or diarrhea has intervened to produce an uncontrolled loss of fluid and electrolytes. In its most critical form, the result is an acute reduction in plasma volume, with circulatory collapse. Short of this, disturbances of acid-base balance may occur and should be prevented by frequent determinations of serum electrolytes, particularly when the decompensation is of long duration and the depletion of the tissue sodium pool may be marked.

In the correction of such disturbances, caution is likewise recommended. An alert house-officer may perform a few rapid calculations based upon the plasma volume as 5 per cent of the body weight, and extrapolate to the extracellular fluid as 20 per cent; but it is well to remember that such calculations are empirical and that the factors governing the migration of substances from one compartment to another are largely unknown. The patient is not a saucepan.

REFERENCES

1. Elkinton, J. R., and Danowski, T. S.: The Body Fluids, Baltimore, The Williams and Wilkins Co., 1955.
2. Gamble, J. L.: Chemical Anatomy, Physiology and Pathology of Extracellular Fluid, Harvard University Press, 1952.
3. Starling, E. H.: The Fluids of the Body, Chicago, W. T. Keaner and Co., 1909.

Bankrupt black market

The dangerous drugs regulations in Hungary were broadly the same as in Britain, but an interesting difference is that a list of addicts was kept in the office of the medical officer of health. All "registered addicts" got an allowance of their drugs at a special chemist's shop, where they always received their supply of the quantity prescribed. The Health Service covered the costs. By this scheme the Government hoped to prevent a black market in morphine, heroin, cocaine, etc. *Dezso Schachter, M.D. The Hungarian National Health Service. Brit. Med. J. Jan.* 16, *1960.*

Depression

The other physical accompaniments of the state [depression] bear careful noting, especially the state of the appetite and the weight, since the degree of severity here will give a most useful estimate of the practical effects on the patient's general functioning. Other curious physical changes may be noted; for example, curly hair may straighten out in a depression only to curl again with recovery. The significance of such changes is not known. *Wendell S. Muncie, M.D. Clinical Importance of Overt and Hidden Depression. Rhode Island M. J. Feb. 1960.*

EEG's in diagnosing epilepsy

Where visceral components accompany the commonly accepted varieties of fits, diagnosis is easy. When these phenomena come by themselves, their epileptic quality may be overlooked. Careful searching through the patient's and the family's history will often be rewarded by other stigmata of epilepsy in the patient or in the genetic pattern.

Electroencephalography is especially useful. When the history is uncertain, and the manifestations are borderline, electrical tracings may support the diagnosis. However, a blind reliance on diagnosis by electroencephalography alone is to be avoided for the following reasons: From 10 to 20 per cent of those having convulsions have normal EEG's. From 10 to 15 per cent of normal persons who have never had a fit have abnormal EEG's. Abnormal EEG's may be found in patients with psychoneurosis and anxiety states. Sydenham's chorea has an EEG pattern common to patients with major attacks. Abnormal EEG's by adult standards are increasingly common in children of decreasing age under 10 years. *Ray Hepner, M.D. Some Unusual Varieties of Visceral Epilepsy. Missouri Medicine. March* 1960.

The Forand Bill and Individual Freedom

Walter L. Oblinger,* *Springfield*

I think you know that a variety of medical care plans for the aged have been introduced in Congress. In addition to the Forand Bill, there is the Javits Bill, the Mills Plan, the McNamara Bill, and the Administration Bill. They all seek to provide medical service to the aged financed through the social security system or general tax revenues, through contributions from beneficiaries, through matching funds to the states, or a combination of these. While they differ in some respects, my observations with the reference to the Forand Bill will more or less hold true for the others.

The Forand Bill (HR 4700), introduced by Aime J. Forand (D-RI), would provide all those persons eligible under social security with free hospitalization up to 60 days a year plus an additional 60 days of nursing home care — total 120 days in any twelve month period. It would also provide surgery, incuding medical, dental, minor surgery, and emergency out-patient service in a hospital or doctor's office.

To finance this the OASI tax would be increased ¼ of 1 per cent initially then rise to 2 per cent in 1969. It is estimated by the Health, Education, and Welfare Department that the cost of the Forand Bill would be $1.1 billion for the first year. However, actuarial estimates produced by the Health Insurance Association of America place the first year costs at between $2.074 billion and $2.387 billion. Costs would spiral in the year 1980 to $7.6 billion.

These figures give no consideration to the fact that historically such estimates on social insurance costs have been low, that these estimates are made on the basis of the 1960 dollar, no consideration being given to the inflationary effects of the legislation itself. Furthermore, no consideration in these estimates is given to demands and pressures for the almost certain expansion and liberalization of benefits once the program gets under way.

Social security taxes would jump. Under the present tax rate schedules, social security taxes by 1969 will be 9 per cent of $4,800 of taxable annual earnings of an employee. The employer and the employee will each be contributing 4½ per cent for a total of $432. Self-employed persons will then be paying 6¾ per cent on the first $4,800 of their earnings or $324 annually. In 1969, if the Forand Bill is enacted in its present form and nothing else occurs to increase social security costs, over 11 per cent of taxable payroll will be needed to pay the costs of compulsory insurance. In other words, the social security tax will amount to $528. This tax is in addition to income tax and other taxes.

It is of the utmost importance that the issues involved in the Forand Bill be clearly defined. The fundamental issue is not the care of the aged. The proponents would like nothing better than to be able to represent to the American public that the medical profession is opposed to the Forand Bill because it is not interested in the aged or that it wants to be free to charge exorbitant fees. The truth of the matter is, as the proponents well know, that for some 2,000 years the medical profession has been dedicated to the medical care of the people. The medical profession has always taken care of the medical needs of the total population, including the aged; and when patients are unable to pay a fair fee, the fees are scaled accordingly, or no fee is charged at all. There is no segment of the American public now going without medical care, except a few living in isolated communities.

The immediate crisis was precipitated by inflation—the rising cost of living—food, clothing, shelter, etc., not just medical costs. While we have reservations about the extent of the need, there is a need for some plan of financing medical care to the aged. Where we differ from the proponents is in the method to be used in meeting the need.

Proponents of the Forand Bill feel and think that it is necessary to propel the Federal Government into a program of actively and directly providing medical service. Of course, this means that the government will have to control the purveyors of the service; in this case, surgeons,

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*General counsel, and director of legislative activities, ISMS. Presented at Springfield Insurance Underwriters Association, May 19.

hospitals, dentists, and nursing homes. The government, in order to budget for the program, will have to control the kind and quality of the services, select the physicians, hospitals, and nursing homes that will provide the services, and set the fees for the service. This is the only way that the government could enter into such a program. It represents a departure from the basic, so-called insurance concept of the social security system. Instead of making cash handouts which presumably have some relation to the monies collected under the program, the government would embark upon a program of socialization by undertaking to provide for the health and welfare of those eligible under the system.

It should be apparent to anyone that, in so doing, the government will embark upon a program that will have no end—a bottomless pit! In the first place, the proposed legislation will not do the job the proponents claim for it. It will cover only 60 per cent of the older population, and it will not provide for any type of medical care other than surgery. How many ailments and diseases attendant upon old age can be remedied by surgery? What about rehabilitation, domiciliary home care, visiting nursing care? Just what are the medical needs of the aged population? Wouldn't it be logical to get facts first —to find out just what the needs are before we attempt to prescribe and apply legislative remedies? And yet that is just what the proponents propose to do with this legislation. And if there is a social problem here, then the program should cover not just 60 per cent but 100 per cent of the group.

Secondly, we know that the social security system has become a political plaything; that every two years when Federal elections are to be held, some further liberalization of the social security system is proposed or passed for the purpose of winning votes. If this liberalization trend continues—and there is no reason to believe that it will not—other persons will be made eligible, and the extent of medical coverage will increase. The newborn, the newlyweds will get consideration. Types of medical care other than surgery, hospitalization, and nursing home care will be offered. If the Forand Bill passes, the precedent and pattern will have been established to completely socialize the medical profession.

The whole concept is foreign to our way of life. The issue here is not the care of the aged, but how shall we take care of the aged under our free enterprise system. If we believe in free enterprise, then solutions should be sought consistent therewith. The medical profession is seeking solutions in the form of voluntary health insurance coverage for the low-income, low-resource citizens over age 65. Such coverage has expanded 170 per cent in the past six years.

The Health Insurance Association of America estimates that 49 per cent of persons 65 years of age and older had some form of voluntary health insurance at the beginning of 1960. It says that in 1952, 59 per cent of the total population had some form of insurance coverage and this was increased by 13 per cent to an estimated 72 per cent by 1960. For the aged population, however, the proportion insured doubled during this period, increasing from 26 per cent to about 49 per cent. The 26 per cent insured in 1952 represented 3.4 million of the then 13 million aged persons.

The 49 per cent of the approximately 15.7 million aged persons represents 7.7 million estimated to have health insurance in January, 1960. In addition to the 49 per cent of the 65 and over who now have health insurance, another 15 per cent, 2.4 million persons, are officially classified as indigent, and provision is made for their individual needs through old age assistance supported by Federal-state matching fund programs. Thus, at the present time approximately 64 per cent of the over-65 population has a hedge against medical care costs. It is further estimated that at the present rate of voluntary insurance growth, 90 per cent of the over-age-65 group will have some form of insurance coverage by 1969.

ISMS program

The Illinois State Medical Society is fully aware of the problem and is offering a solution consistent with our free enterprise system. In conformity with the program developed by the Illinois State Medical Society, the Illinois Medical Service (Chicago Blue Shield) has made available the Series 65 Blue Shield Certificate for persons over 65. It provides not only benefits for surgery and in-hospital medical care but other services as well. As I understand it, this new certificate is similar to the commonly held general Blue Shield certificate, with the excep-

tion that it provides 30 visits per admission for in-hospital medical care; the maximum indemnity provided for diagnostic x-ray and pathologic services has been increased and, of course, does not cover obstetrical care.

The cost of the new contract is $1.65 per month. At the same time, Hospital Service Corporation (Chicago Blue Cross) offered the Series 65 Blue Cross Certificate which provides 30 days of Blue Cross service benefits per hospital admission at a cost of $9.65 per month or $11.30 per month for the total package. In so far as Blue Shield is concerned, if an unmarried subscriber's annual income shall not exceed $2,000 and his net worth shall not exceed $15,000, or a married subscriber's income together with that of his spouse shall not exceed $3,000 or their worth not exceed $20,000, the indemnity provided by the certificate shall constitute payment in full for the service rendered, provided the physician rendering the service has agreed to participate in this phase of the program.

The Federal government should seek to stimulate such local programs and confine itself to indirect programs that match funds with local programs: a mortgage plan to finance construction of nursing homes, one-time grants for construction of needed facilities, greater income tax credits for medical costs, higher maximum amounts of taxable earnings and credits permitted to social security beneficiaries so that they can remain active and productive. The government should explore the feasibility of income tax credits to employers who hire older persons. The government, however, should never intervene directly in human relationships, as it is proposed that it do in the physician-patient relationship.

The real issue

The issue posed by the Forand Bill is that of freedom. Not only is the freedom of the physician to practice medicine as he chooses involved; the freedom of all of us is in jeopardy. In a free society the very essence of freedom is to make decisions, whether those decisions be right or wrong. If a person desires to use his money to buy a television set rather than to provide voluntary insurance for his old age, that fundamentally is his decision, or it should be. The worst feature about the social security system is that it gives the individual no choice. Undoubtedly there should be some social security system. The medical profession has never taken a position against social security. But the individual should be allowed to choose to be covered under such a system or to provide for his old age himself through other programs. When we reach the point where society makes the decisions for the individual and thus takes away his right to make those decisions, then it can be said that the individual no longer has freedom, that we have arrived at a regimented society, whether we call it socialism, fascism, or something else.

If the government can impose its will upon the medical profession and decide what kind of medical service the individual should have, then the way is clear for the government to make similar decisions for all of the other professions and trades in this country. The way is clear for the government to move in on the grocer, or the tailor, and audit his costs and tell him what quality of material should be used, how much labor should go into his product, and what he should charge.

Common false impressions

In any discussion of the social security system, there are some misconceptions that should be cleared up. You hear much said about the existence of a trust fund, that taxes paid into the system are insurance premiums, that social security is an insurance plan, that contributions are set aside in the trust fund to be paid out in the form of benefits when the contributor reaches retirement age. The truth of the matter is that there is no trust fund as such; all funds paid into the social security system go into the Treasury to be replaced by bonds. That money is spent as received for general tax purposes. Of course, the bonds don't stay in the trust fund very long because, for the most part, current social security benefits are being paid out of current receipts. To say it another way, the primary source of the money for current benefit payments is the current contributions from employees, employers, and the self-employed; a fund of "modest" amount is developed which arises from any excess of current contributions over current benefit payments; this fund permits a contribution schedule which progresses in an orderly known amount, acts as a buffer for variations in contributions and benefit outlays, and

provides a modest current-income source from interest earnings (7½ per cent). The important thing to remember is that in the insurance sense no trust funds exists—no reserves which go toward financing payment of benefits. All or substantially all of the contributions being received are being passed out to those persons retiring at age 65 or otherwise qualifying for benefits.

According to *Actuarial Study No. 48,* a study of long-range cost estimates under the 1956 Amendment to the OASDI Act issued by the social security system, it was reported that covered employees and their employers, as a class, pay only about 42 per cent of the value of their benefits, whereas new entrants and their employers will pay 169 per cent of the value of their benefits. The new entrant into the social security system (and his employer) is paying $1.69 for each dollar he can expect to receive from the system. Self-employed new entrants may expect to contribute $1.25 for each dollar of benefits. This process of passing on the cost of current benefits to coming generations will accelerate, and should the Forand Bill or some other scheme of financing medical care of older persons through the social security system pass, we shall shortly reach the point of resistance on the part of new entrants. We shall also place the system itself in jeopardy.

Right now the system has a greater contingent liability than the entire national debt. It has been variously estimated that between $90 billion and $300 billion is needed as of 1959 (as opposed to $22 billion now in the fund) to bring the reserve fund into some semblance of actuarial soundness. What all this adds up to is the fact that the cost for present benefits to persons eligible for benefits under social security is being passed on to coming generations. This, to me, is morally reprehensible. In the hearings on the Forand Bill, Walter Reuther made the following statement on behalf of the AFL-CIO:

> "We recognize that the new benefits will cost money, and we stand ready to meet the cost. Under the Forand Bill, social security taxes would be increased by a quarter of 1 per cent of taxable payrolls, both for employees and employers."

Doesn't Mr. Reuther know that the new benefits will probably cost double or triple such rate? Doesn't he know that the cost for current workers would be many times greater than the initial ½ of 1 per cent and still infinitely greater for new entrants? By what right does Mr. Reuther, or the national Congress for that matter, speak for the young of this generation and the members of future generations who will bear the actual cost?

This brings me to another point. Just how will the margin for personal savings be affected by compulsory social security contributions which are scheduled to increase by 80 per cent in the next ten years? For 1959, social security contributions of $9,612 million will be about 43 per cent of estimated personal savings of $22,000 million, and the latter has been estimated as 7 per cent of disposable income. If the 1969 contribution rate of 9 per cent were in effect in 1959, social security taxes estimated at $17,300 million would be 78 per cent of personal savings of $22,000 million. And this before adding the cost of the Forand Bill! This is where this welfare state legislation leads you. Just what right does Congress and the Walter Reuthers of this country have to mortgage our future savings?

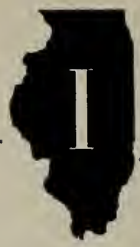
I could say much more about the threat this poses to life insurance, the inflationary effects of social security which directly challenge older people, but I shall content myself with this admonition of Judge Brandeis from the Case of Olmstead v. United States (1928).

> "Experience teaches us to be most on our guard to protect liberty when the government's purposes are beneficent."

The medical profession stands as a roadblock, a last obstacle on this road to the welfare state. The medical profession is directly challenged and has the responsibility of meeting the challenge. To medicine has gone the honor of defending our freedom — our way of life. It is time for all men who believe in the free enterprise system to rally and enter the fray.

If you feel that these issues are important — if you are concerned about freedom of opportunity for your sons and grandsons; about the tax burden being piled upon coming generations; about increasing government intervention in the life of the individual; about the weakening of the moral fibre of our nation; I urge you to sit down and write to your Congressman, to your U.S. Senators, and urge them to vote against any enactment of compulsory care of the aged. I urge this association to adopt a resolution against the Forand Bill.

From the Secretary's Office



There is now only one administrative ISMS office, and that is located at 360 N. Michigan Ave., Chicago 1, Ill. There is a branch office in Springfield, in charge of the General Counsel of the society, Mr. Walter L. Oblinger.

Our German confreres have been having trouble with their government, so we are informed by a WMA news item. The goverment wanted to increase benefits under the insurance scheme. The patient was to pay the doctor who had to turn in the money to the government. The patient, of course, thinks the money goes to the doctor as an increased fee. So far, the physicians have prevented this.

Members who missed the annual dinner also missed seeing the famous Hawaiian dance group of Montgomery, Portes, Goodyear and Rose. Portes and Goodyear have modified the "Little Grass Shack" version by adding a touch of the square dance. Why not, now that Hawaii is a state?

Mrs. Kathryn Simmons, or "Kay" as she is known to most of us, has resigned. She will leave us on July 15. Kay will be missed by all of us, and we wish her all kinds of good luck in her retirement.

Two interesting talks were given at the public relations luncheon, one by Federal Judge Julius Miner of the Northern Illinois District and the other by Judge David W. Peck, former presiding justice of the Supreme Court of New York County. Both of these talks concerned impartial medical testimony.

The antivivisectionists are concentrating on Congress to legislate their desires and have formal support in Senator John Sherman Cooper of Kentucky. His bill (S3570) is identical in major provisions to the German law adopted when the Nazis first came into power in 1933. (See Editorials, p. —.) It was sponsored by Hermann Goering, who was honorary president of the German National Antivivisection Society. It did not prohibit animal experiments but strangled research with so much red tape that it was not worth the effort. It was cited at the Nuremburg trials as one reason why the Nazi experimenters turned to the use of humans.

A new periodical has just appeared, "Medico-legal Digest," Vol. 1, No. 1, edited by Milton Solin. Under his leadership and with the excellent advisory board listed on the title page, this should prove a well worth-while publication. This issue contains some very interesting material.

Some of the important actions of the House of Delegates at the recent meeting were:

1. Divided the Committee on Medical Service and Public Relations into two committees.
2. Went on record as being opposed to all forms of socialism whether or not the medical profession was involved.
3. Commended Adams County for its academic school program.
4. Raised dues $30 per year.
5. Urged members to continue nurse recruitment drive.
6. Urged annual polio vaccination injections (booster shots).
7. Made numerous changes in the Constitution and By-Laws.

George F. Lull, M.D.

[*Ed. Note*: *This page was written during Dr. Lull's tenure as acting executive administrator.*]

THE P. R. PAGE

John A. Mirt

Work of committee is divided

The House of Delegates at the 120th annual meeting in May approved changes in the Constitution and By-Laws of the Illinois State Medical Society which have a bearing on the future PR and medical service activities of the Society.

Heretofore, these functions have been carried on by the Committee on Medical Service and Public Relations. The Edlund report recommended that two separate committees be entrusted with these duties. The House approved the recommendation, and two committees were established—a Committee on Medical Service and a Committee on Public Relations.

The Committee on Medical Service will consist of five members and the president and secretary-treasurer, ex-officio. Its activities will be carried on under the supervision and direction of the Council. Members of the committee will be appointed by the Council for three-year terms, excepting that initially the terms will be staggered: two for three years, two for two years, and for one year.

This committee will be responsible for informing the membership of all legislative matters of interest to the medical profession in Illinois. It will maintain surveillance of all bills introduced in the legislature having direct or indirect effect on the practice of medicine or on the health of the people of Illinois.

Effective liaison also will be maintained with the AMA Committee on Legislation so that the ISMS will be kept informed concerning Federal legislation. The committee also will recommend a legislative program for approval by the Council and promulgate this program among the members of the Society.

The Committee on Public Relations will consist of six members, to be chosen by the Council for three-year terms. Initial appointments terms will be staggered, with two named for three years, two for two years, and two for one year.

It will be the duty of the committee to prepare and submit a public relations program for the ISMS to the Council for approval. Such a program should include public service projects of long and short durations which will increase the public's esteem for the medical profession.

Both committees will embark upon expanded programs provided for through an enlarged office staff and an increase in dues. This not only should improve the position of the Society and the medical profession in the eyes of the public but it will establish the ISMS in the forefront of medical organizations fighting for the maintenance of a high standard of health services.

House takes stand on socialism

The House of Delegates also adopted a statement of policy regarding socialistic proposals, such as bills of the Forand type. The House approved a reference committee recommendation:

"The ISMS firmly opposes socialism in all of its forms. The compulsory health schemes, which the welfare state planners are promoting at this time, are examples of socialism, which not only the medical profession but the public must vigorously oppose."

When asked why medicine in Illinois is against the Forand Bill or similar proposals, the answer is "It is against any form of socialism."

Adams County program commended

Since 1957, the Adams County Medical Society has been promoting academic scholarship achievement in Quincy and Adams County high schools by awards to those in the upper echelon of their classes. The program is designed to encourage superior and talented youth, but it has provided also effective P.R. for the profession.

This fact was recognized by the House of Delegates, which adopted a reference committee report commending the county society for its worthwhile promotional efforts.

Other county societies may obtain details by writing to Dr. Harold Swanberg, 209-224 W.C.-U. Building, Quincy.

EDITORIALS

Were *You* represented?

The 120th Meeting of the ISMS has come and gone. In some ways it was a very successful and interesting meeting; in others it was disappointing. At a time when the private practice of medicine is at the crossroads a large number of our members did not attend the meeting, nor were they represented.

Strunsky, the Russian-American author, once said "Statistics are the heart of democracy." If this is true, the ISMS needs the services of a cardiologist, as the statistics of our annual meeting leave much to be desired.

The House of Delegates is the policy-making body of our state society, and its actions are binding on all our members. The House meets, as a rule, only once a year, so many important items have to be covered in a relatively short period. This year at the opening session of the house 30 component societies out of a total of 92 were not represented. The figures for the second and third sessions were even more depressing as 32 and 37 component societies were conspicuous by their absences.

Very often physicians are critical of the officers of their medical organizations and their methods of conducting society business. Sins of omission and commission of the officers are popular subjects of discussion during locker and dressing room seminars. It is stated quite often that the society, either local, state, or national as the case may be, is run by a small entrenched group so that the average member has little or no voice in its affairs.

How and why do these "entrenched groups" take over? The answer is simple. The members of these groups are usually the only ones who are willing to sacrifice the time, money, and hard work to carry on the affairs in which every member has a vital and important stake. If one third of the component societies of an important state society, such as ours, are not represented in the policy-making body, then the members of those societies either have implicit faith and confidence in their confreres or lack interest in what is happening to their profession.

Let 1961 be different, and let us have 100 per cent participation. This is the only way we can have true democratic action. If you are not repesented, you have no grounds for fault-finding; and if you think that you are improperly represented, you should take steps to correct this on the local level.

George F. Lull, M.D.

Heat and Drugs

Summer is the time of year to check the drugs in the medical bag for signs of deterioration from heat. Some products such as antibiotics maintain their potency for a year or two provided they are stored in temperatures below 80°F. But the temperature in the trunk or glove compartment of a car standing in the sun may go as high as 120°F. Deterioration is rapid, especially when the antibiotic is in solution or suspension. Pills, capsules, and powders are more stable than the liquid products, but they deteriorate also when the temperature is high.

Some antibiotics change color or become more turbid under these conditions; others crumble. But many lose their potency without undergoing visible changes in appearance. There is nothing to do about the problem except to discard antibiotics that have been in the bag for more than a week, especially when subjected to intense summer heat.

Many cars are air conditioned, but none to our knowledge come equipped with a refrigerator. Small, portable, ice box units are available, but they are troublesome and more suitable for picnics. We'll pass along the idea of a car refrigerator to help out the family doctor.

Mr. White to direct medical services, economic research

Mr. Roger N. White will join the staff of ISMS in August as director of medical services and economic research. He comes to the Society after serving six years as executive director of the Hospital Council of Lackawanna County, Pa. From 1951-54 he was staff secretary of the Medical Society of the State of Pennsylvania, during which time he was associated with Mr. Robert Richards, now ISMS exective administrator.

A native of Pennsylvania, Mr. White has a pre-engineering diploma from Keystone Junior College, and there where he excelled in athletics.



Roger N. White

He graduated from Pennsylvania State University with a B.S. degree in education as a chemistry and mathematics major and taught those subjects and coached athletic teams in school districts in the state for four years. After having served three years as assistant director of the Industrial Training Sales Division of the International Correspondence School in Scranton, he returned to the university in 1949 and for two years was district extension service representative.

During World War II Mr. White served with the U.S. Navy and was discharged with the rank of lieutenant.

Mr. White is a member of the Hospital Association of Pennsylvania, the American Hospital Association, and the Scranton Chamber of Commerce. He has served as a membership chairman of the Scranton YMCA, chairman of the finance committee of the United Churches of Lackawanna County, and secretary to the Foods Division of the Scranton United Fund.

He is married and has four children.

Request to county society secretaries

The annual report of the Committee on Archives stressed the importance of getting today's medical news preserved in some permanent form. Everyone whom we have consulted has been of the opinion that this can best be accomplished by having county society secretaries send such news items to the "News of The State" section of our Illinois Medical Journal. This will give us a permanent printed and filed record which can easily be consulted by physicians or others interested in medical history.

A half century hence today's medical activities will be medical history, and most probably will seem as antiquated and possibly as illogical as many medical ideas and practices of 1850 to 1900 seem to us. However, let's write them down and keep the record straight. And while doing this, be sure to preserve any historical material pertaining to medicine which may be found in old trunks and attics and send such records to the Committee on Archives at the Chicago office of the ISMS. Too often such old records are consigned to the incinerator without careful examination and appraisal.

Tom Kirkwood, M.D.
Committee on Archives

Antihistamines for hypertension

Lipman[1] reported a two-pronged attack on hypertension aimed primarily at eliminating stress. He treated 19 civil service employees with a simple anti-stress diet and an antihistamine. All had been disabled previously with long-standing symptomatic hypertension with established elevation of the diastolic pressure. All were instructed to avoid irritants such as tobacco, stimulants such as coffee and tea, and depressants such as alcohol or other habit forming drugs. The sodium intake was limited, and animal fats

restricted to the barest minimum. Oleomargarine was substituted for butter and skimmed milk powder for whole milk. Chicken, lean fish, whole grain cereals, citrous fruits, and green and leafy vegetables were recommended.

The patients received an antihistamine in the form of Chlor-Trimeton Repetabs® averaging 20 mg. per eight hours. Clinical improvement was observed. Symptoms were ameliorated even though a marked lowering of the blood pressure was not always noted. Many lost weight. They were able to return to full duty status with a minimum loss of man hours due to illness.

This study is not well controlled and credit for success cannot be given to any single phase of treatment. Lipman was of the opinion that the antihistamine played a definite role in reducing stress (aside from its sedative action). He contends that the antihistamine is capable of performing many of the functions of adrenalin and when Chlor-Trimeton is present in the blood, it will discourage the production of adrenalin in response to stress. This hypothesis will need much more research before it can be accepted.

1. Lipman, Daniel C.: Stress and Hypertension: Use of Antistress Diet and Antihistamine. J. Am. Geriatrics Soc. 8:177 (March) 1960.

Antivivisection and red tape

Now pending in the national congress is S3570, a proposal by Senator John Sherman Cooper of Kentucky to require licensure of every individual scientist who might work with vertebrate animals under any federal grant, contract, or project using federal funds. Laboratories in which animal research were to be conducted would be inspected and issued "Certificates of Compliance." Research plans would have to be submitted by the Secretary of the Health, Education, and Welfare Department for approval before the projects could be started. Presumably variations would not be permitted. Detailed annual reports would have to be submitted. The National Institutes of Health would be assigned police duties.

The Cooper Bill has no constructive purpose, but, as Dr. Lester R. Dragstedt, president of the National Society for Medical Research, points out, it proposes "to drain away the time and resources of scientists who are trying to find better ways to save lives and alleviate suffering." Dr. Dragstedt has branded the Cooper Bill as "an attempt by the antivivisection cult to strangle medical research with red tape."

Walter L. Oblinger

Editorials from Other Journals

The buttonholer

A meeting is a melting pot, attended by people with a variety of miens and motives. Some attend as dedicated individuals fighting for a cause. Others attend as dyed-in-the-wool playboys, trying to get a loose woman tight.

From both of these groups, and from all those in between, comes the Professional Buttonholer. He's the individual who corners you in a meeting room or a hotel corridor and spends from 20 minutes to an hour expounding on a subject of absolutely unilateral interest.

If you've been exposed long enough and often enough, you know that the Buttonholer never asks a question. To do so would permit an answer and possibly terminate a one-sided conversation. You also know that the problem is often compounded by bourbon breath or chronic halitosis.

We could go on for hours, telling how to spot a Buttonholer across a crowded room. But instead we'll close with one simple observation: As far as Buttonholers are concerned, don't be one. *GP. January* 1960.

Photo story of the
1960 Annual Meeting



Dr. O'Neill cheerfully installs president. At installation ceremonies, Dr. Joseph T. O'Neill, retiring president, presents to Dr. H. Close Hesseltine, incoming president, the insignia of office, the medallion and gavel.



Three new ISMS officers pledge support—(left to right) Secretary-Treasurer Jacob E. Reisch, Springfield; President H. Close Hesseltine, Chicago; and First Vice President Andrew J. Brislen, Chicago. Second Vice President Clinton D. Swickard, Charleston, was unable to attend the meeting.



Dr. J. Ernest Breed (left) and Dr. Theodore LeBoy of Chicago are the newly elected members of Council of the ISMS.



Dr. E. A. Piszczek, Chicago, became the new Chairman of the Council.



First Harold Camp Memorial Lecture audience filled the ballroom at the Sherman Hotel. Dr. Ernest S. Crawford, assistant professor of surgery, Baylor University College of Medicine, Houston, delivered the address for Dr. Michael E. DeBakey, his associate who was delayed in his return from Europe.



At the Public Relations Luncheon Judge Julius H. Miner (left) U.S. District Court, Chicago; and (right) the Honorable David W. Peck, formerly presiding justice of the Supreme Court of the State of New York spoke on their experiences in impartial medical testimony. Dr. Edwin S. Hamilton (center), chairman of the Committee on Medical Service and Public Relations, presided. Dr. Hamilton is president-elect.



Dr. Joseph B. Kirsner as he delivered the Oration in Medicine Wednesday afternoon.



Dr. Willis J. Potts spoke on pediatric surgery in the Oration in Surgery on Wednesday



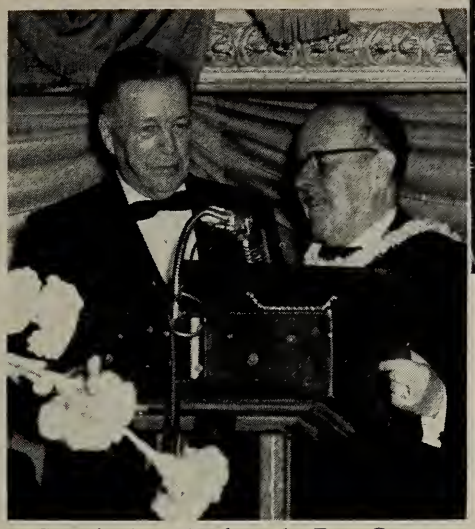
Reference Committee No. 4 hears reports of Council Committees in Tuesday morning session. Left to right, Drs. Harry Mantz, (Madison Co.), James H. Cross, Chicago; Paul D. Reinertsen, (Fulton Co.); and Chairman Maurice Murfin, (Macon Co.). Dr. Quentin D. Young, fifth member of the committee, was sitting with the audience.



Giant wheel-hat of Mrs. Glen H. Harrison, Lake Forest, won the prize for designing a chapeau that best depicted projects of her county Woman's Auxiliary. Five other county presidents held steady the spokes.



The Distaff Line-Up for 1960-61. Mrs. J. V. Prohaska (fifth from the left) turns over the president's gavel to the incoming president, Mrs. C. L. Wunsch. Officers for the coming year are (left to right), Mrs. G. J. Sciaraffa, Elgin; Mrs. W. Scrivner, East St. Louis; Mrs. A. S. Watson, Glen Ellyn; Mrs. R. E. Westland, Skokie, president elect; Mrs. Prohaska, Chicago; Mrs. N. Chester (installing officer), Chicago; Mrs. Wunsch. Aurora, Mrs. W. Roller, Monmouth; Mrs. J. Koenig, Chicago; Mrs. N. DuPuy, Quincy.



Surprised and pleased, Dr. George F. Lull listens to Dr. Joseph T. O'Neill read from the plaque the citation for meritorious service to the medical profession presented to him at the Annual Banquet.



Aloha! Thursday night at the grand finale of social functions, the Annual Banquet tuned to Hawaii, old friends and new donned bright colored leis in celebration of the spirit of the evening. Seated at one of the 60 tables (clockwise from the left) are Mrs. and Dr. Norman L. Sheehe, Mrs. and Dr. Samuel H. Bess, Mrs. and Dr. Francis X. Graff, Dr. Paul D. Reinertsen, Mrs. and Dr. Maurice D. Murfin, and Dr. Elvin L. Clark, all from downstate.



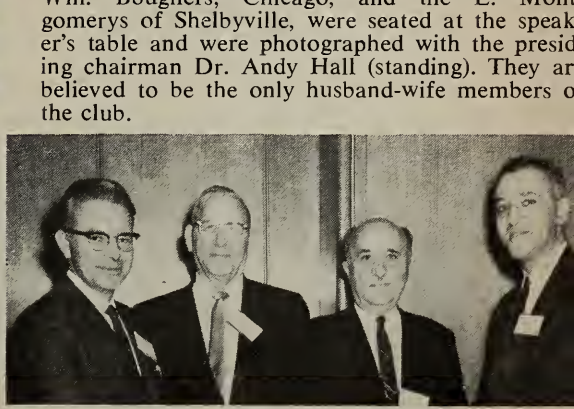
Banquet speaker Virgil W. Peterson, acting director of the Chicago Crime Commission.



and hearty 50-Year Clubites and some guests, over 175 strong, cele- d at luncheon in their honor Tuesday, May 24. At table in the fore- nd (clockwise from the left) are Miss Helen Branstrator, Chicago t of Dr. Hill); Drs. Joseph Prendergast, Oak Park; E. M. Hill, Chi- Dubley T. Dawson, Georgetown; Andrew C. Schoch, Chicago; A. Knapp, Winter Park, Fla.; William Cooley, Peoria; and Dr. pp's daughter, Mary, also of Winter Park. At table center back- nd (counterclockwise) are Dr. Irving H. Neece, Decatur; Mrs. Stone Dr. F. Lee Stone, both physicians past presidents of the Society, and G. C. Otrich, Councilor for many years.



Physician teams in home and office, (left) th Wm. Boughers, Chicago, and the E. Mont gomerys of Shelbyville, were seated at the speak er's table and were photographed with the presid ing chairman Dr. Andy Hall (standing). They ar believed to be the only husband-wife members o the club.



M.D.'s run in the family. Two of the father an son combinations attending the 50-Year Clul luncheon: (left to right) Drs. A. C. Wendt, Jr. and Senior, and Dr. S. H. Soboroff and his son Dr. J. Soboroff, all of Chicago. Both fathers be came members of the Club that day.

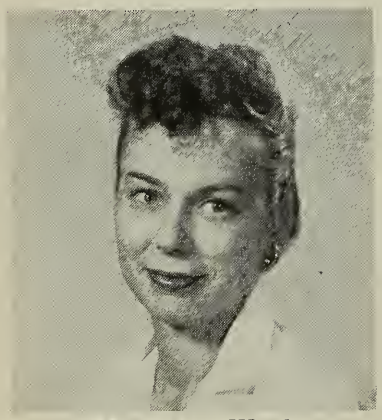


Proud wives stand by the presidents, Drs. John J. O'Neill (left) and H. Close Hesseltine.

ISMS NEWS



Mrs. Wanda Ross



Mrs. Mary Ward



Mrs. Kathryn Simmons

Dropping out of the picture

"The old order changeth giving place to new"

This month the door to the six-room Monmouth office of the Illinois State Medical Society on Main Street closed and marked the end of an era begun in 1923. Within these rooms most of the administrative work of the Society had been carried on until last October, under direction of Dr. Harold Camp, excutive secretary.

Few members of the Society ever visited there, but all have had bills for dues and receipts postmarked *Monmouth* and many an announcement as well.

Mrs. Frances Zimmer and Mrs. Jane Swanson have moved to Chicago to join the headquarters staff, but Mrs. Wanda Ross and Mrs. Mary Ward will remain with their families in Monmouth.

"In an office of four since last October, everyone did a little of everything, and it's hard to departmentalize us," says Mrs. Zimmer. However, Wanda kept the membership card records for dues, did all the bookkeeping, Journal subscriptions, kept records of sales of exhibit space and billing for the technical exhibitors at the annual meetings. Now after 11 years with the society, she plans to devote her time to husband and home.



Monmouth office on second floor, center building now closed.

Mary ran the "machinery" in the workroom—the electric mimeograph, and folding machines, and addressograph—and kept the mailing lists of the Society's 10,000 members in order. She made up the cross-files on membership records, handled the monthly AMA membership reports, did the correspondence, printing of programs and mailing letters for the postgraduate medical education programs.

Mrs. Ward after 13 years with ISMS changes her role to mother and housewife, Byran James having arrived on the scene just prior to the annual meeting in May.

Both girls were well known especially to the doctors downstate. One of them attended all the postgraduate meetings with Dr. Camp and until this year, worked behind the registration desk at the annual meetings.

The Society on July 15 loses another longtime employee, Mrs. Kathryn Simmons, who is retiring. Kay began working for ISMS in the 1920's when her father, Henry G. Ohls, M.D., was managing editor of the Illinois Medical Journal. She provided the liaison between physicians and public for the Educational Committee from 1925 until it was dissolved four years ago, arranging lectures for lay groups and the "live" radio programs on popular health subjects, then conducted by the Committee. Since that time she has worked for the Scientific Service Committee and then the Post Graduate Medical Education and Scientific Service Committee arranging for speakers for county medical society programs.

Kay, who recently moved to Evanston, intends to spend some time with her four grandchildren and relax for a while. Her sunny disposition and her fund of "who's who" information will be greatly missed.

To all three we say thank you for jobs well done.

Registration at annual meeting tops record

Registration figures for the 1960 annual meeting of the Illinois State Medical Society show a record attendance total of 3,387, over 400 more than have signed in for any one of the last three years. Physician attendance, which included residents, was 1,994, or 111 more than registered last year. Guests number 736 and included interns, medical students, nurses, and wives of physicians. The Woman's Auxiliary had 315 members present, and personnel for the exhibitors was 342.

Over 1,500 physicians registered during the first two days, 880 on Tuesday, opening day, and 58 as late as Friday.

For the first time, four girls from the Chicago Convention Bureau helped behind the registration desk in charge of Mrs. Kathryn Simmons of the Chicago office.

Dr. Piszczek heads Council

Edward A. Piszczek, M.D., Chicago, field director of the Suburban Cook County Tuberculosis Sanitarium District for 11 years and clinical professor and chairman of the department of preventive medicine and public health, Stritch School of Medicine of Loyola University, is the newly elected chairman of the Council, Illinois State Medical Society.

Dr. Piszczek has served on the Council for 10 years and has been chairman of the Tuberculosis Committee and a member of the Committee on Medical Service and Public Relations.

He received his M.D. degree from the Loyola University School of Medicine in 1933 and his M.P.H. from the Harvard School of Public Health in 1939.

He served as director of the Cook County Department of Public Health from 1940-1949 and has been field director of the sanitarium district for the last 11 years.

Fete 50-Year Club members

About 175 members and guests of the 50-Year Club met at their annual luncheon May 24 to reminisce.

Dr. Andy Hall, chairman since 1938, assisted by Dr. E.A. Piszczek, newly elected chairman of the Council, presented framed certificates of membership and lapel emblems to 15 of the 36 new membems in the Chicago area; those not in attendance have received their membership insignia. Twenty-nine downstate members have, or will be, welcomed into the club at meetings of their county societies this year.

Dr. James H. Hutton, a past president of the Society, was luncheon speaker. He gave an informal talk on "Odds and Ends about Public Health in Illinois."

House selects committeemen

Committeemen of the House of Delegates of ISMS were elected at the annual meeting of the society in May to serve during the year 1960 to 1961 as follows:

Grievance Committee—Drs. Percy E. Hopkins of Chicago and Victor V. Rockey of Freeport.

Committee on Medical Education and Hospitals—Drs. Kenneth C. Johnson of Chicago, chairman; Ward Eastman of Peoria and George F. O'Brien of Chicago.

Medico-Legal Committee—Drs. George C. Turner of Chicago, chairman; Charles Allison of Kankakee.

Committee on Medical Testimony—Drs. Leo P. A. Sweeney of Chicago, chairman; Harry D. Nesmith of Salem.

Committee on Prepayment Plans and Organization—Dr. E. Lee Strohl of Chicago.

Committee on Medical Benevolence—Dr. F. M. Nicholson of Chicago.

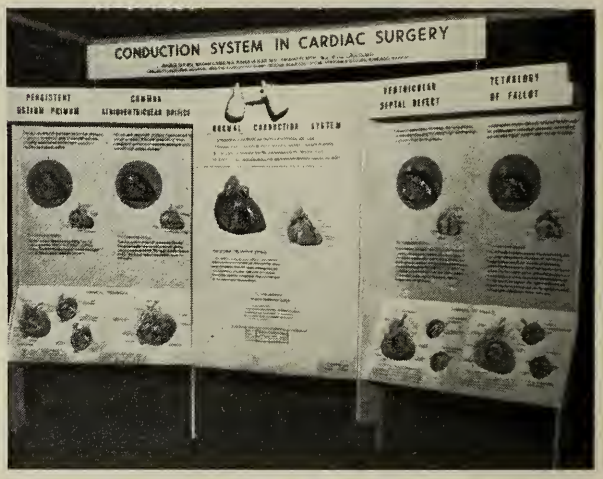
Medals awarded scientific exhibits

From 31 scientific exhibits on view at the annual meeting in May, awards were made to those displaying the most original work and to those having the most educational value.

For original work, the Gold Medal was Awarded to the exhibit, "The Crico-Arytenoid Joint," prepared by Drs. Hans von Leden and Paul Moore from Northwestern University and the Gould Foundation. The Silver Medal Award went to the exhibit, "The Repair of Tissue Deficient Hernias by Aortic Implants," prepared by Drs. Samuel J. Fogelson and Roy G. Cooksey. No Bronze Medal was awarded this year in this category.



For educational value, the exhibit, "The Conduction System in Cardiac Surgery," prepared by Drs. Maurice Lev, William L. Riker, Arthur De Boer, Thomas Baffes, and W. J. Potts from Children's Memorial Hospital, Chicago, won the



Gold Medal Award. The Silver Medal went to the exhibit, "Effective Control of Toxemia," prepared by Drs. Herbert E. Schmitz, Michael P. MacLaverty, and Robert S. Pavlic.

Three Bronze-Medal-winning exhibits for educational value displayed their yellow ribbons: "Cholangiography—Operative and Postoperative," prepared by Drs. Karl A. Meyer, Peter A. Rosi, Nicholas J. Capos, and Joseph J. Litschgi; "Hydatidiform Mole and Chorioepithelioma," prepared by Dr. Frederick H. Falls and Charlotte S. Holt; and "Leiomyoma and Leiomyosarcoma of the Gastro-Intestinal Tract," prepared by Drs. Hildegarde Schorsch and Hyo Hyun Byun.

The Committee on Awards—Drs. Gilbert H. Marquardt, Ward Eastman, and William E. Adams, chairman—selected the winners. Dr. Coye C. Mason was chairman and director of scientific exhibits.

AT THE EDITOR'S DESK



Nation's Human Resources

The average person eats 4.1 pounds of food per day, or 1,500 pounds per year. Two-thirds of this is made up of dairy products and eggs, meats, fish, and poultry; and fruits and vegetables. This bit of statistical information is included in a 90-page booklet, "Health, Education, and Welfare Trends, 1960," dealing statistically with the nation's human resources. Some other facts cited are:

1. For each of the past two years hospital construction outlays reached almost $1 billion. Four fifths of the money was non-Federal.
2. In spite of reductions in recent years there are still well over 600,000 resident patients of mental hospitals.
3. All Federal grants-in-aid totaled $6.3 billion in fiscal year 1959. Grants for health, education, vocational rehabilitation, welfare, and employment security accounted for $3.5 billion.
4. Over 30 percent of all persons entering the fifth grade now go on to college.

Copies of the booklet may be obtained from the Supt. of Documents, U. S. Printing Office, Washington 25, D.C., at 50¢ each.

Pharmaceuticals

Aralen (Winthrop) is getting to be one of those all-purpose drugs that raises our sense of skepticism. The latest, in case you missed it, was a report of dramatic and sustained relief in four cases of infectious mononucleosis. This article appeared in the May 7 issue of the JAMA.

Aspirin is available now in suppository form. It is recommended by Suppositoria Labs., Inc. for infants and children and also for adults suffering from peptic ulcer or otherwise irritated gastric conditions.

The Public Health Service investigated a new family of compounds, decarboxylase inhibitors, and found that alpha-methyl dopa, a Merck product, lowered blood pressure consistently. These inhibitors control some of the body's natural chemical reactions and alpha-methyl dopa blocks the formation of norepinephrine, epinephrine, and possibly serotonin. The drug also exerts a tranquilizing and sedative effect. Clinical trials will continue.

Hygroton is Geigy's new sulfonamide antihypertensive and saluretic. The competition among duretics is keener now that many substitutes for Diuril are available. The term saluretic has not yet appeared in our Stedman's Medical Dictionary, but it is most descriptive of the action of these new drugs.

Eli Lilly has introduced a new prenatal vitamin mineral supplement (En-Cebrin) to meet the increased nutritional demands of pregnancy and lactation. One capsule daily supplies all the essentials including a phosphorus-free calcium, and it is packaged in an attractive apothecary type bottle that our little mothers can keep as a lasting memento.

A Shocker

A catalog on hospital restraints arrived and shocked us into thinking about this type of business. It came from the Humane Restraint Company, who have pioneered and manufactured these products since 1876. The restraints are most attractive in themselves, and the wristlets and anklets will be lined with soft leather or foam inner lining if desired. We wonder whether their business has suffered since the advent of our modern tranquilizers. We have been told repeatedly that these drugs make the aggitated docile, and if so there is little or no need for restraints.

This catalog would have made a first-class inquisitionist drive, and in this respect was published several centuries too late. We suggest to the Humane Restraint Company that they find new uses for their excellent and well made devises. They could go into the business of making safety belts or harnesses used by mothers to keep small fry in tow, restraints for animals at zoos and those needed by veterinarians treating large animals—or save all for the next war.

Methuselahs Postponed

The Metropolitan Life Insurance Company tells us that the average length of life of the American people reached a new high of 69.7 years in 1959. The previous high was 69.6 years in 1954 and also in 1956. It was 69.5 years in 1958. Their statisticians doubt whether the record of gain in life conservation during the past century can be achieved again. The greatest margin for improvement lies in the development of new weapons for postponing and treating degenerative conditions.

Cartwheelers and Candy Stripers

The American Hospital Association points with pride to the 150,000 teenagers who are serving as volunteers in American hospitals. They are known as volunteens, cartwheelers, or candy stripers. They do a million-and-one odd jobs varying from reading to patients to carrying messages. It is a wonderful hedge against delinquency.

The original candy striper came from the Evanston Hospital, where the girls wore red and white striped pinafores. This was back in the early 1940's. The name originated in a statement by an elderly patient who received a tray from a nurse instead of a volunteer. He inquired, "Where's my pretty little candy striper tonight?"

Deaths by Accidental Poisoning

Accidental poisoning deserves our serious consideration, even though the incidence has decreased slightly since 1949. Approximately 1,400 deaths from this cause are recorded annually in the United States, and one fourth of these are children of preschool age. Barbituric acid and its derivatives are responsible for nearly one out of every four fatal accidental deaths. They are most troublesome in California whose residents account for about one third of the reported deaths from barbiturates. Overdoses of aspirin, chloral hydrate, paraldehyde, and other analgesics and soporifics are high on the list of causes. Other chemicals include wood and denatured alcohols, kerosene, household pesticides containing arsenic compounds, and heavy metals.

Long-term Anticoagulant Therapy Questioned

A VA cooperative study on the long-term treatment of cerebral vascular accidents failed to confirm the value of anticoagulants in preventing further strokes or lowering mortality. Nine hospitals participated in this study which involved 189 cases. They stressed extensive precaution in the use of these drugs because of the probability of increasing the chance of hemorrhage.

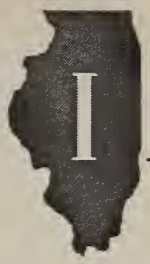
Those of us who heard Dr. Crawford give the Harold M. Camp Lecture may wonder where anticoagulants enter this picture. They demonstrated that 30 per cent of all strokes resulted from an occlusion of a vessel outside the head such as in the internal carotid. They found endarterectomy the treatment of choice.

Paying for That M.D.

According to the Association of American Medical Colleges, the average cost of a four year medical education (class of 1959) was $11,642 or $2,911 a year. The individual student and his family are paying the largest portion (82%) of the costs with minor assistance for outside agencies. The association's Datagram points out that 16 per cent of the 1959 graduating class of medical students receive no help from their families. In contrast, 36 per cent received $6,000 or more. Twenty five per cent received $100 to $2,900 and 23 per cent from $3,000 to $5,900. Further studies show that the parents of these students are in a slightly higher income bracket than the average American white urban family. Eighty-one per cent of the students earn money to pay their bills by working during summer vacations and during the academic year.

It is unfortunate that most of the students must do work that has nothing to do with medical education. Datagram states that we must draw upon a broader socio-economic base within the population if we expect to increase the number of physicians. In addition, medical students will need more financial assistance in order to eliminate unproductive work.

ANNOUNCEMENTS



Dr. Askey new A.M.A. president

Dr. E. Vincent Askey, Los Angeles surgeon, was inaugurated as president of the American Medical Association at its annual meeting in Miami last month, succeeding Dr. Louis M. Orr, Orlando, Fla. He thus becomes the spokesman for more than 175,000 physicians.

In 1952 he was elected vice speaker of the AMA House of Delegates and served as speaker from 1955 to 1959. He is a former president of the Los Angeles County and California State Medical associations.

Dr. Askey received his M.D. degree from the University of Pennsylvania in 1921. He is on the surgical staff of St. Vincent's Hospital.

In 1958 Dr. Askey was awarded the honorary degree of Doctor of Science from Allegheny College. The citation said that despite a busy practice, he found time to serve as "a member and president of the Los Angeles City Board of Education, combining high ideals, responsible citizenship, distinguished professional achievements."

August clinics for crippled children

Eighteen clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The division will hold 14 general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing service. There will be two special clinics for children with cardiac conditions and two for rheumatic fever and one for cerebral palsy.

August 3—Alton (Rheumatic Fever), Alton Memorial Hospital
August 3—Hinsdale, Hinsdale Sanitarium
August 4—Macomb, District Hospital
August 5—Chicago Heights (Cardiac), St. James Hospital
August 9—East St. Louis, St. Mary's Hospital
August 9—Peoria, Children's Hospital
August 10—Champaign-Urbana, McKinley Hospital
August 11—Springfield, St. John's Hospital
August 12—Evanston, St. Francis Hospital
August 16—Belleville, St. Elizabeth's Hospital
August 17—Chicago Heights, St. James Hospital
August 18—Elmhurst (Cardiac), Memorial Hospital of DuPage County
August 18—Litchfield, Madison Park School
August 18—Rockford, Rockford Memorial Hospital
August 23—Effingham (Rheumatic Fever), St. Anthony Hospital
August 23—Peoria, Children's Hospital
August 24—Elgin, Sherman Hospital
August 25—Bloomington A.M. (General), P.M. (Cerebral Palsy), St. Joseph's Hospital

Changes in diagnostic laboratory service

Effective July 1, 1960, two changes were made in the diagnostic service furnished by the laboratories of the Illinois Department of Public Health.

1. Agglutination tests with patient's serum vs. the organisms of paratyphoid A (Salmonella paratyphi A) and paratyphoid B (paratyphi B) were discontinued as a routine service. Paratyphoid A fever has always been so rare in Illinois as to be practically nonexistent. Paratyphoid B is encountered only a little more frequently. Furthermore, there are so many cross-reactions with other Salmonellae that the interpretation of findings is difficult. Formerly blood specimens submitted for a typhoid agglutination test have also been tested for paratyphoid A and B agglutinins whether requested by the physician or not. Since June 30 only the typhoid agglutination test is performed on such specimens.

Culture of the clot for typhoid bacilli will be done as heretofore, and cultural examination of stool and urine specimens for any or the enteric organisms will be continued.

2. Animal inoculation for the isolation of tubercle bacilli will no longer be done. Culture methods are now employed which are approximately as successful as guinea pig inoculation and can be done at a fraction of the cost. Animals will continue to be used when required to distinguish type of acid-fat strains.

It is anticipated that savings resulting from the above changes will permit the introduction of new diagnostic services under development.

Medical examination of civil airmen

Effective June 15, 1960, the Federal Aviation Agency will require that student and private pilots be given their medical examinations by designated medical examiners. This rule reinstates a practice in effect from 1926 until 1945. Dr. James L. Goddard, the Civil Air Surgeon, has emphasized that any physician may be considered eligible for designation as an examiner.

His statement, made public February 11, follows:

In order to have a better understanding of the proposed rule, I wish to point out that it is designed to accomplish the following needed improvements in the administration of the Agency's medical certification program.

1. To maintain a group of medical examiners who are clearly responsive to the needs of public safety in the performance of examinations and the issuance of medical certificates to airmen.
2. To permit the administration of training programs to maintain the quality of performance of medical examiners and to permit the dissemination of special instructions pertaining to the needs of civil aviation.
3. To bring into the program those physicians who have the professional qualifications and a demonstrated interest in the medical certification field.
4. This would permit the designation of any qualified physician who, by his application, has demonstrated interest in the program.

Those physicians in localities where flying activities are conducted may wish to consider filing an application for designation by writing to the Civil Air Surgeon, Federal Aviation Agency, Washington 25, D.C.

Designation as an aviation medical examiner will qualify the designee to examine both Class II (commercial) and Class III (student and private) airmen, including control tower operators. Instructions concerning the required procedures, standards, and equipment will be supplied to those who apply.

Since commercial and airline transport pilots have always been required to obtain examinations from specifically selected physicians, there are presently some 2,000 aviation medical examiners previously designated and located throughout the country. Expanding aviation activities will result in a continuing need for additional examiners. There are at present some 400,000 active civil airmen of whom approximately 240,000 are examined each year.

PG courses in otolaryngology and bronchoesophagology

An intensive postgraduate basic and clinical program for practicing otolaryngologists is being given by the University of Illinois College of Medicine, department of otolaryngology, September 24 through 30. The daytime and evening program will include a wide variety of current advances in management, therapy, and philosophies, and a review of basic morphologic features. Panel programs are designed to bring out special features of otologic and reconstructive surgery and tumors of the head and neck. Luncheon chats are an important part of the daily program.

The department will conduct also a postgraduate course in laryngology and bronchoesophagology from October 17 through 29 under the direction of Paul H. Holinger, M.D.

Registration will be limited to fifteen physicians.

Interested registrants for either course should write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12.

WMA to meet in Berlin

The XIVth General Assembly of The World Medical Association will be held in Berlin, September 15-22, 1960. The German Medical Association has scheduled its own annual meeting in conjunction with the General Assembly, and the opening and closing plenary sessions of the two organizations will be held together. Both meetings and all activities associated with them will be held in the new Berlin Convention Hall.

In addition, an International Film Program is scheduled during the entire period—its theme: Postgraduate Education. The excursion on September 22 will include a sight-seeing tour through the East Sector of Berlin and will end with a cruise on Havel Lake.

International congress of physical medicine

The Third International Congress of Physical Medicine will be held August 21-26, 1960, at The Mayflower, Washington, D.C.

The preliminary prospectus covering the international conference carries information in detail. A copy may be had on request by writing to Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 N. Michigan Avenue, Chicago 2.

Foreign fellowship program for students

A fellowship program designed to further medical education by sending future doctors to remote areas of the world has been announced by the Association of American Medical Colleges.

The three-year program, established under a $180,000 grant from Smith Kline & French Laboratories, is open to all medical college students who have completed their third year of study. Scheduled to begin this summer, the program will permit an average of 30 students to participate each year.

The medical opportunity inherent in working with dedicated men already practicing in Africa, Asia, and other far-off places provides a first-hand experience in the care of patients that cannot be obtained in the formal academic environment." The SK&F Foreign Fellowships also provide "an excellent opportunity for cultural development since these preceptorships enable the students to view at first hand the mores and ethical backgrounds of other people."

Eligible students who are prepared to spend an average of 12 weeks working in foreign locales have been urged to submit applications to their respective deans for review. Following initial screening, up to three applications from each school will be forwarded to a distinguished panel of physicians who will make up the selection committee.

The committee includes Dr. Richard A. Young, dean, Northwestern University Medical School, Dr. Carroll L. Birch, professor of medicine, University of Illinois College of Medicine, and Dr. Robert G. Page, assistant dean, University of Chicago, the School of Medicine.

Awards will be made on the basis of the applicant's ability and objectives with special consideration being given to those programs which cannot be realized in the United States and through which the student can bring back valuable knowledge to this country.

Plan to aid Ob-Gyn residents

The American College of Obstetricians and Gynecologists has set up a Higher Education Loan Program (H-E-L-P) to enable resident physicians to complete their training in obstetrics and gynecology. Loans up to $5,000 will be made to help physicians through their specialty training period and early practice.

H-E-L-P will start operations with an initial working fund of $36,000, contributed by the College and its district organizations. This will be added to through individual contributions and grants if necessary.

For information, write to Mr. Donald F. Richardson, Executive Secretary, ACOG, 79 West Monroe Street, Chicago 3.

Ob-Gyn board examinations

Applications for certification in the American Board of Obstetrics and Gynecology, new and reopened, Part I and requests for re-examination in Part II are now being accepted at the Office of the Secretary, 2105 Adelbert Road, Cleveland 6. Deadline for receipt of applications is August 1, 1960. No applications can be accepted after that date.

The following change in requirements for certification was made by the members of the American Board of Obstetrics and Gynecology at the recent annual meeting in Chicago.

"A Resolution was passed at the recent annual meeting of this Board which eliminates the submission of Case Reports as part of Part I Examination. It is required, however, that each candidate eligible to take the Part II Examination bring to the place of examination, a duplicate list of Hospital Admissions as submitted with his or her application. *This change in requirements is not retroactive and therefore applies to candidates making application for the 1961 examinations.*"

It has also been resolved by members of the Board that Applications for Appraisal of Incomplete Training will no longer be accepted for review by the Residency Review Committee.

Study on Hand-Schuller-Christian disease

The cooperation of physicians is requested in a study of eosinophilic xanthomatous granulomatosis, and most specifically Hand-Schüller-Christian disease, being conducted by the Radiation Branch of the National Cancer Institute in the Clinical Center of the National Institutes of Health, Bethesda, Md. Its primary purpose is a search for therapeutic methods which may favorably affect the course of the disease.

Patients appropriate for this study are those with a histopathological diagnosis consistent with some phase of eosinophilic xanthomatous granulomatosis who have active disease. It is preferable, of course, that such patients not be seriously ill, as this precludes long-term studies of effects. In order to minimize the effects of prior treatment, those patients who have not received antifolic-acid, radiation, or steroid therapy for at least one month prior to their evaluation shall be considered most appropriate for the program; but previously treated patients will be considered for admission. Accepted patients will be studied for various periods of time and may be followed subsequently by either the referring physician or physicians at the Clinical Center. A comprehensive and individual program will be instituted for each patient and will include appropriate supportive and symptomatic care as well as the experimental therapy.

Physicians interested in the possibility of referring such patients should write to Dr. Charles G. Zubrod, Clinical Director, National Cancer Institute, Bethesda 14, Md.

Consider this fall . . .

The Two Postgraduate Courses

presented by

The Chicago Medical Society

NEWS of the STATE

County

Cook

Appointments: Dr. Edmund A. Gorvett, assistant professor of medicine at Northwestern University Medical School, was recently installed as president of the medical staff of Passavant Memorial Hospital, and Dr. Franklin Lounsbury, assistant professor of surgery at the medical school, was named president-elect.

Dr. Waldemar Dasler has been promoted from associate professor to professor of biochemistry at the Chicago Medical School. He has been a member of the faculty since 1948.

Dr. Heinrich Necheles has been appointed professor of medicine at the Chicago Medical School. For the past 20 years he has been director of the department of gastrointestinal research at Michael Reese Hospital. He has previously been on university faculties including the University of Chicago, where he is still a professorial lecturer.

Elections. The Chicago Laryngological and Otological Society at their meeting in May elected Dr. Henry B. Perlman, president; Dr. Myron M. Hipskind, vice president; and Dr. Robert B. Lewy, secretary-treasurer.

At the annual meeting of the Chicago Pediatric Society in May, officers elected included Dr. Matthew M. Steiner, president; Dr. James A. Conner, vice president; Dr. Harry L. Faulkner, secretary; and Dr. I. Pat Bronstein, treasurer.

Officers elected by the Chicago Society of Industrial Medicine and Surgery include Dr. Richard E. Heller, president; Dr. Richard Perritt, vice president; Dr. Bille Hennan, secretary; and Dr. Charles Drueck, treasurer.

Chicago Surgical Society officers elected for the coming year include Dr. Walter G. Maddock, president; Dr. Robert L. Schmitz, secretary; Dr. Paul V. Harper, treasurer.

The Chicago Urological Society has elected the following officers: Dr. J. Kenneth Sokol, president; Dr. David Presman, vice president; and Dr. James H. McDonald, secretary-treasurer.

Research Laboratories. Ceremonies dedicating the Samuel Jefferson Sackett Research Laboratories at Northwestern University Medical School were held June 3, the fifth anniversary of the $600,000 grant for research into the cure and treatment of rheumatic fever and related diseases. The work on rheumatic fever has been under the direction of Dr. Gene H. Stollerman, associate professor of medicine.

Dr. Stollerman cited accomplishments since the Sackett Laboratories were established: (1) The discovery that mild streptococcal infections that are not epidemic do not cause rheumatic fever; (2) laboratory studies demonstrating new antibacterial enzymes in the blood; (3) new enzymes found only within the more virulent streptococci; (4) discovery of a new test for detecting immunity to streptococci causing rheumatic fever and nephritis that will help to evaluate usefulness of vaccines.

Research developments have attracted research project grants from many agencies to expand the work to many phases of immunology and to provide research fellowships to undergraduate and postgraduate medical students.

Tours "Down Under." Dr. Meyer A. Perlstein, chief of the Children's Neurology Clinic at the Cook County Hospital, will hold cerebral palsy clinics and speak before medical groups in New Zealand for about three weeks, starting July 10, then in Australia for two weeks.

Northwestern and Rehabilitation Institute Affiliate. The Rehabilitation Institute of Chicago, 401 E. Ohio Street, became an affiliate of Northwestern University Medical School in April. The affiliation further strengthens a close working relationship which has been in effect for several years.

The Institute presently houses the Mid-western Prosthetic Education Center and the Prosthetic Research Center, both of which are under the supervision of the Medical School.

Under the agreement, Institute facilities and professional personnel will be available to the university for instruction of undergraduate students in physical medicine and physical therapy.

Dr. Richard H. Young, dean of the Medical School was appointed to the Institute board of directors as a representative of the university.

New tb clinic. The Chicago Municipal Tuberculosis Sanitarium Board will construct a new out-patient clinic in the centrally located Medical Center District to replace eventually the work of two older clinics in the city. The land was acquired through a $125,000 appropriation bill passed by the First Special Session of the 71st General Assembly and approved by the Governor.

Dr. Vail Receives Howe Medal. Dr. Derrick T. Vail, professor of ophthalmology and chairman of the department at Northwestern University Medical School, has been awarded the Lucien Howe Gold Medal of the American Ophthalmological Society. The award, highest honor in American ophthalmology, was given in recognition of leadership in his field during the past 35 years through his work as an editor, teacher, clinician, and surgeon. Internationally known, Dr. Vail is author of more than 50 papers and several textbooks, and also serves as editor of the American Journal of Ophthalmology and as associate editor of several other medical publications.

Gift to medico. Dr. Thomas A. Dooley, cofounder of medico, last month received a $45,000 gift of intravenous solutions, including vitamins and sets for administering them, from Baxter Laboratories, Inc. of Morton Grove, for use in his jungle hospitals in Indo-China. Included was the stipulation that Dr. Dooley may have more when these are used.

"This shows the people of Asia that only a nation that allows capitalism to flourish allows gifts to organizations such as medico," Dr. Dooley said in accepting the gift, and described the pharmaceutical industry's response to the program as "fantastic."

Lake

Members of the Lake County Medical Society and their wives enjoyed a golf tournament at the Glen Flora Country Club in Waukegan in June. The social hour and dinner meeting in the evening was the last meeting until September.

Lee-Whiteside

A combined meeting of the medical society and medical auxiliary of the Lee-Whiteside counties met for a special program June 16 at the Lincoln Manor Restaurant in Dixon. A program "Medicos in India" followed a prime rib dinner. Dr. W. McNichols, Sr., of Dixon gave an account of his experiences in "We Go Tiger Hunting," a 30 minute film he made. Rockford's Dr. Hugh Johnson chose "Fulbright to India" as his subject.

Logan

Appointments. Dr. Armin M. Grossl and Dr. Paul Walter Tillman have been appointed assistant superintendents of Lincoln State and Dixon State schools respectively.

Dr. Grossl, born in Chicago, joined the Lincoln staff in November, 1957. Dr. Tillman had been a member of the medical staff at Lincoln State school since August 1955.

Madison

At the June meeting of the Madison County Medical Society, Dr. Axel N. Arneson of St. Louis, professor of gynecology at Washington University School of Medicine, spoke on "Natural History of Cervical Cancer."

St. Clair

New Voice Club. Under the guidance of the St. Clair County Cancer Society, a group of laryngectomees got together to form a New Voice Club. A laryngectomee from the county, who has developed an ability at esophageal speech and has been assisting as a volunteer in teaching this method in the St. Louis New Voice Club, is in charge of the instruction of members. Rehabilitation of new and old patients is the purpose of the weekly meetings of its members.

Warren

Dr. Kenneth E. Ambrose, Monmouth, spoke on "Modern Concepts in the Diagnosis and Treatment of Leprosy," before the Monmouth Rotary Club.

General

Lectures Arranged Through the Illinois State Medical Society. John Albert Novotny, Peoria, clinical instructor in orthopedic surgery at the University of the Illinois College of Medicine, addressed the Bureau County Medical Society in Spring Valley, May 10, on "Fractures in the Upper Extremities in Children."

The Winnebago County Medical Society at their Annual Clinic Day in Rockford, May 11, heard Charles P. McCartney, associate professor and secretary of the department of obstetrics and gynecology, University of Chicago School of Medicine, speak on "Pre-Eclampsia."

John Arnold, associate professor of medicine, University of Chicago School of Medicine, took part in a panel before the Organization for the Southwest Community, May 24, discussing "Medical Careers."

Louis C. Johnston, clinical instructor in medicine, University of Illinois College of Medicine, spoke at the Y.M.C.A. Citizen's Forum, June 25, on "Health—Your Most Priceless Possession."

Alan R. Feinberg, associate in medicine, Northwestern University Medical School, addressed the Bureau County Medical Society in Princeton, June 14, on "What's New in Allergy."

Radio Program. On June 22, A. L. Aaronson, clinical associate professor of medicine, The Chicago Medical School, discussed "Your Hay Fever," on the radio program "Your Health Comes First" over station WJJD.

This is a public service program sponsored by the Illinois State Medical Society in cooperation with radio station WJJD.

Election: The Illinois Psychiatric Society has elected the following officers, all of Chicago: Dr. Joel S. Handler, president; Dr. Melvin Sabshin, president elect; and Dr. Harold M. Visotsky, secretary-treasurer.

Deaths

Charles Livingston Agnew, Aurora, a graduate of Meharry Medical College, Nashville, in 1895, died March 4, aged 92.

F. W. Barry*, Coffeen, who graduated from Washington University School of Medicine, St. Louis, in 1902, died recently, aged 83.

Frederick E. Buechner*, Delmar, N. Y., formerly of Chicago, who graduated from the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1901, died March 15, aged 82. He served on the staff of the Grant Hospital for many years.

Joseph P. Cangelosi, Chicago, who graduated from Chicago Medical School in 1936, died May 30, aged 52. He was senior surgeon at St. Elizabeth's Hospital.

Paul C. Fox*, retired Coral Gables, Florida, formerly of Chicago, who graduated from Rush Medical College in 1912, died May 8, aged 74. Formerly an Oak Park gynecologist and staff member of West Suburban Hospital for more than 35 years, he was a member of the American College of Obstetrics and Gynecology, the Central Association of Obstetrics and Gynecology, and the Chicago Gynecological Society, and a Fellow of the American College of Surgeons. He was on the staff of Rush Medical College many years.

Henry Frost Hooker*, Danville, a graduate of Northwestern University Medical School in 1908, died May 19, aged 80.

Harold Mark Hoover*, Joliet, a graduate of the University of Illinois College of Medicine, Chicago, in 1933, died February 13, aged 60. He was a member of the American Academy of General Practice, was associated with St. Joseph's and Silver Cross hospitals, and served as physician for the Joliet public grade schools from 1942 to 1953.

Herman Josephy*, Chicago, formerly of Hamburg, Germany, who graduated from Universitate Rostock Medizinische Fakultat, Rostock, Mecklenberg, in 1910, died May 19, aged 73. He was a former neuropathologist at Chicago State Hospital, and from 1949 to 1952 had been an associate professor of neurology at Chicago Medical School. At the time of his death, he was pathologist at Bethany Methodist Hospital.

L. J. Jurek*, retired, Chicago, who graduated from Chicago Medical School in 1935, died May 31, aged 69.

W. F. Kalisz*, Chicago, who graduated from Loyola University School of Medicine in 1916, died May 28, aged 67. He was president and editor emeritus of the National Medieal and Dental Association of America. At the time of his death, he was senior staff surgeon at St. Elizabeth's Hospital.

Harry George Leon*, retired, Chieago, who graduated from Loyola University School of Medieine in 1919, died May 26, aged 72. He was a former coroner's physician.

Philip Lewin*, Chieago, noted medical author and internationally recognized authority in his field, died May 13, aged 71. He was graduated from Rush Medieal College in 1911, served his internship at Children's Memorial Hospital, was at St. Luke's Hospital for two years, and then served his resideney at Paris University. He beeame a certified orthopedic surgeon in 1935. At the time of his death he was attending orthopedic surgeon at County Hospital, senior attending orthopedie surgeon and former chairman of the department of bone and joint surgery at Miehael Reese Hospital, consulting orthopedic surgeon at Municipal Contagious Disease Hospital, professor emeritus at Northwestern University Medical Sehool, where he had been chairman of the department of bone and joint surgery, and professor of orthopedie surgery at Cook County Graduate Sehool. Dr. Lewin, eolonel in the Medical Corps of the Army of the United States, served in both World wars and was commanding offieer of the Michael Reese 16th Evaeuation Hospital Unit in its organization for World War II at Camp Blanding, Fla., from 1942 to 1946. He was a founder and former seeretary, vice president, librarian, and historian of the Ameriean Academy of Orthopedic Surgeons, a past viee president of the Chieago Orthopedie Soeiety, and vice chairman of the Medieal Advisory Committee of the National Foundation for Infantile Paralysis. He was also a member of the Ameriean Orthopaedie Association, the American Medieal Assoeiation, the Ameriean Rheumatism Assoeiation, and a Fellow of the American College of Surgeons.

Louis Litton*, Chieago, who graduated from the University of Illinois College of Medicine, Chicago in 1924, died April 11, aged 66.

Roderick Hugh Maguire*, Canton, Illinois, who graduated at St. Louis University School of Medieine in 1918, died February 9, aged 69.

Joseph Moles*, Oak Forest, Illinois, who graduated at Chaddock School of Medicine, Quincy, in 1917, died January 28, aged 68.

Alfred Nicholas Murray*, retired, Evanston, eye, ear, nose and throat surgeon, who graduated from Rush Medical College in 1901, died May 26, aged 87. He was the author of several books on ophthalmology and a former president of the Chieago Ophthalmological Soeiety and a fellow of the American Medical Association.

Meredith B. Murray*, River Forest and Maywood, who graduated at Creighton University School of Medicine, Omaha, Nebraska, in 1914, died April 28, aged 72. He was a captain in the Army Medical Corps during World War I and joined the U.S. Public Health Service upon his return and later the Veteran's Administration. He served as assistant chief surgeon at Hines Veterans hospital for six years. At the time of his death he was a senior member of the Oak Park and Westlake hospitals. He was past president of the DesPlaines Branch of the Chicago Medical Society, a fellow of the Ameriean College of Surgeons and the International College of Surgeons, and a eharter member of the Catholic Physieians Guild.

Beattrice C. Opre*. Victoria, who gradnated from Chieago College of Medicine and Surgery in 1908, died reeently, aged 81.

Dominic A. Palmisano*, Chicago, who graduated from Chicago Medical School in 1923, died May 3, aged 60. He was a senior staff member at St. Elizabeth's Hospital, former president of the Italian Doctors Association, and the Chicago Medieal Soeiety's Northwest Branch.

Daniel F. Paul*, Rock Island, who gradnated from The Hahnemann Medieal College and Hospital, Chicago, in 1917, died recently, aged 70.

D. D. Raber*, Bloomington, who graduated from Bennett Medieal College, Chicago, in 1908, died recently, aged 82.

Walter Schiller*, Chicago, noted pathologist, author, and caneer researcher who devised the Schiller test for early diagnosis of carcinoma of the uterine cervix, died May 2, aged 72. A graduate of the University of Vienna, Austria, in 1912, he beeame director of the laboratories of the Second Woman's Clinie at the University of Vienna before coming to the United States. He also served as director of the laboratories at the Jewish Memorial Hospital in New

York. In Chicago he headed the laboratories of Cook County, State, Roseland, and the Women and Children's hospitals, and was consultant pathologist at the latter and also at Columbus and Cuneo Memorial hospitals. He was a member of the American Medical Association and a Founding Fellow of the College of American Pathologists.

H. E. Schmitz*, Chicago, who graduated at Loyola University School of Medicine, Chicago, in 1927, died April 17, aged 59. He was chairman of the department of obstetrics and gynecology at Stritch School of Medicine of Loyola University and of Mercy Hospital, where he also was Director of the Institute of Radiological Therapy. He was a professor of gynecology at Cook County Graduate School. He was chief of staff at the St. Vincent's Infant and Maternity Hospital and the Lewis Memorial Maternity Hospital. At the time of his death he was vice chairman of the Board of Directors of the American Cancer Society. As a charter member of the Illinois Division of the Society, throughout the years he served as chairman of the Executive Committee, the Medical and Scientific Committee, and the Professional Education Committee. In 1952 he received the Annual Award of the Illinois Division for contributions leading to better diagnosis and more effective treatment of carcinoma of the cervix. He had been a member of the following societies: American College of Obstetrics and Gynecology (president-elect), Central Association of Obstetricians and Gynecologists (1958 president), American Gynecological Society, American Association of Obstetrics and Gynecology, the American Radium Society, a member of the American Medical Association, and a Fellow of the American College of Surgeons.

Helmut P. G. Seckel*, Chicago, who graduated at the Chicago Medical School in 1925, died April 13, aged 59. He was an assistant professor at the University of Cologne, Germany, before joining the University of Chicago as professor of pediatrics in 1937.

George O. Solem*, Chicago, who graduated from Rush Medical College in 1917, died May 5, aged 72. He was an associate of the late Dr. Bertram W. Sippy, and a member of the staff of Lutheran Deaconess Hospital.

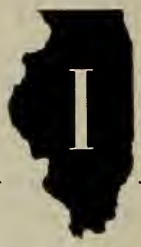
Raymond J. Thoma*, Chicago, who graduated from St. Louis College of Physicians and Surgeons in 1918, died June 7, aged 69. He was on the staff of Evangelical Hospital.

Robert Henry Woodruff, Springfield, a graduate of Northwestern University Medical School in 1904, died February 14, aged 83. He was chief of vital statistics of the Illinois Department of Public Health.

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**Indicates member of the Illinois Medical Society.*

BOOK REVIEWS



Observations on "Direct Analysis" The Therapeutic Technique of Dr. John N. Rosen. Morris W. Brody, M.D. $2.95. Pp. 104. New York, Vantage Press, 1959.

This small booklet really warrants no review that can be presented for the benefit of the readers of the *Illinois Medical Journal*. Dr. Rosen has created a dramatic, even drastic, direct treatment of the paranoid schizophrenic in which he literally "forces" from his patient the latent meaning of his illness. This technique is new and is practiced but by a few analysts to the present, but is not accepted by the majority of psychotherapists. A few case reports are given and the treatment technique is presented, useful perhaps to the interested psychoanalyst, but of interest to few others.

Louis D. Boshes, M.D.

Preventive Medicine. Herman E. Hilleboe, M.D., and Granville W. Larimore, M.D. $12.00. Pp. 731. Philadelphia, W. B. Saunders Co., 1959.

This is the effort of 31 contributors, practically all of whom are heads of various departments of the State of New York Department of Health. The editors, who are also contributors, are outstanding men in their field and they have produced a text that should be valuable to all groups interested in preventive medicine. The approach to the subject is, as stated by the editors, to distinguish between the prevention of occurrence and prevention of progression of disease and disability. This secondary type of prevention is more difficult, more costly, and less likely to be as successful as the primary type; still medicine is faced with it daily, and often it is too late to do very much about it.

The book is divided into three parts: "Prevention of Occurrence," "Prevention of Progression," and " Supporting Services for Preventive Medicine." Part I contains chapters on water supplies, milk-borne illness, waste disposal, accidents, occupational health, V.D., virus diseases, nutritional defects, dental health, and a number of other important subjects in the field of preventive medicine. Part II covers screening methods for a number of diseases, rehabilitation, alcoholism, narcotic addiction, etc. Part III has chapters on health education, social work, epidemologic methods, and related subjects.

The short chapter on Periodic Health Inventories contains tables indicating the "yield" (per cent positive) of various tests (taken from Roberts, N. J., "Periodic Health Maintenance Examinations"). The author of the chapter, Frank W. Reynolds, M.D., estimates the cost of a complete checkup outside of the hospital to be approximately $50 to $100, depending on the number of tests required. He calls attention to the fact that if this cost is budgeted, it amounts to only one or two dollars per week.

Abstract of Council Actions

Meeting of June 26, 1960

ISMS REQUESTS HEARINGS ON HR 12580

Dr. Hamilton, Chairman of the Committee on Medical Service and Public Relations, and Mr. Oblinger, General Counsel, reported on legislative activity related to health programs for the aging. The Council approved the following telegram which was sent to Senators Paul H. Douglas, Everett M. Dirksen, Lyndon Johnson and Harry F. Byrd:

ILLINOIS STATE MEDICAL SOCIETY RESPECTFULLY REQUESTS YOUR ASSISTANCE IN HOLDING ADEQUATE HEARINGS BY THE SENATE FINANCE COMMITTEE ON HR 12580 PARTICULARLY TITLE SIXTEEN. BELIEVES SUCH FAR REACHING LEGISLATION SHOULD NOT BE ENACTED WITHOUT OPPORTUNITY FOR ALL TO BE HEARD. THIS SOCIETY BELIEVES THIS APPROACH TO PROVIDING MEDICAL CARE TO AGED IN ACCORD WITH FREE ENTERPRISE PRINCIPLES.

H. Close Hesseltine, M.D., President

This message was composed in conformity with AMA policy established at the annual meeting in June.

ACTION ON HOUSE DELEGATES RESOLUTIONS

Resolution #18 -- Medical Examining Panel

The Chairman of the Council, in consultation with General Counsel, was authorized to recommend to the Director of the Department of Registration and Education names of individuals who may be called upon to serve on a panel as examiners in the basic sciences and clinical subjects.

Resolution #7, 8, 10 -- Kendall County; #22 -- Effingham County; #26 to 32 -- Will Grundy County; all dealing with some aspect of the over-all problem of the aging.

The Chairman of the Council was authorized to appoint a committee to study these resolutions and prepare recommendations for the Council's consideration for further House of Delegates action next May.

WHITE HOUSE CONFERENCE ON AGING

Dr. Cannady, Chairman of the Committee on Aging, submitted a report on the forthcoming State Meeting on the White House Conference on Aging. He requested councilors to contact regional directors of the IPAC regarding adequate physician representation at the meeting.

SPRINGFIELD OFFICE LOCATION

Dr. Reisch, secretary-treasurer, described a tentative location for the regional and legislative office in Springfield. The Council approved the location, subject to examination and approval by the previously appointed Regional Office Committee.

EYE EXAMINATION FORM FOR PUBLIC SCHOOLS

Council approved a form submitted by Dr. Weisbaum, Chairman of a special committee appointed to draft one to adequately cover the eye exam made compulsory by House Bill #30. The form will bear the notation ". . . as approved by the Committee on Eye Health of the Illinois State Medical Society."

BUSINESS REFERRED TO COMMITTEES

Dr. Hesseltine presented a letter from David Kinzer, Illinois Hospital Association, in re infection control in hospitals. Referred to Committee to Co-operate with the Illinois Hospital Association.

Dr. Hesseltine also presented a letter from Andy Glosecki, National Foundation, in re the Foundation's revised policies on polio patient aid. Referred to Committee on Polio Control.

Mr. Richards presented two resolutions passed by Illinois Pharmaceutical Association in re group practice pharmacies. Referred to Ethical Relations Committee.

Dr. Montgomery, Chairman of the Finance Committee, recommended that the fiscal year be changed to coincide with the calendar year to simplify auditing procedures. Referred to the Committee on Constitution and By-Laws and to the Executive Administrator.

REPRESENTATIVES TO CONFERENCES

The Chairman of the Council was authorized to appoint representatives to the AMA regional legislative meeting at French Lick, Ind., August 12-13, and two representatives to the Regional Forum on Veterans Affairs at Indianapolis, Sept. 17.

GENERAL ADMINISTRATIVE MATTERS

1. In accordance with AMA policies on the retirement of persons over 65 years old, the Council empowered the Finance Committee to alter the retirement plan so that employees might be retained past the age of 65, subject to annual physical examinations to be paid for by the Society.

2. The Executive Administrator was authorized to invest surplus cash in short term government securities, subject to approval by the Finance Committee.

3. Council approved recommendation by the Chairman of the Journal Committee and the Director of Publications that advertising rates for the Journal be increased 5% effective January 1, 1961.

4. The Council committees were presented by Dr. Piszczek and were approved. Lists will be distributed as soon as the members accept their appointments. Mr. Richards presented his assignments of staff directors to the committees and these were approved.

ELECTION OF EMERITUS AND RETIRED MEMBERS

Council approved emeritus status for J. Carl Hall, Centralia; Archibald L. Hoyne, Chicago, and Thomas I. Stines, E. St. Louis, Robert E. White, Hollywood, Florida, was elected to retired status.

The chapter on Ionizing Radiation crowds a lot of valuable information into 20 pages including a glossary of radiological terms and a bibliography of 25 references.

A vast amount of material of value to the student or practitioner of preventive medicine has been included in this manual and it is well indexed. It should find wide reception in the field for which it was intended.

George F. Lull, M.D.

An Atlas of Neurosurgical Techniques. James L. Poppen, M.D. $28. Pp. 522. Philadelphia, W. B. Saunders Company, 1960.

This is a very unique book if for no other reason than that it is the only book of its kind. Practically every known neurosurgical technique, except stereotaxic surgery, is discussed and portrayed in beautifully executed drawings.

The author is recognized as one of the great technicians in present-day neurosurgery. His incisions for exposure of the various parts of the intracranial cavity are rather versatile. I am sure that he would be the first to admit that technique cannot be demonstrated on a printed page, and this is one of the criticisms of this kind of book. Many of the steps of a neurosurgical procedure are portrayed well. But, unfortunately, the difficult aspects of removing a meningioma, for example, are not shown. Neurosurgeons are not the only ones who could profit by studying this book. It would be excellent for the operating room nurse and the surgeon's assistant as a guide or reminder of steps prior to assisting in a neurosurgical operation.

Briefly stated, this is a very good book by a recognized, experienced, neurological surgeon on a subject which receives entirely too little attention today.

Daniel Ruge, M.D.

Modern Nutrition in Health and Disease. Michael G. Wohl, M.D., and Robert S. Goodhart, M. D. $18.50. Pp. 1152. Philadelphia, Lea & Febiger, 1960.

Nutrition, like other aspects of medicine, is so dynamic that a textbook can scarcely keep up with the changes. The first edition of this book, published about five years ago, carries a preface stating that its organization is based on Wohl's "Dietotherapy," but that extensive revisions had been made because of rapid advances in nutrition over the previous decade. The preface to this second edition describes the revisions, deletions, and additions required by progress over the past five years, half the period between the first two books. If a third edition is brought out in two and a half years, many more revisions will be needed, so fast does our knowledge of various aspects of nutrition grow. The role of inborn errors of metabolism in mental retardation of children and the exciting results being obtained with dietary treatment of phenylketonuria are cases in point.

The 59 contributors include such well knowns as Ancel Keyes, Bargen of Mayo's, Crohn of Columbia, and many other university and industrial scientists. There are new sections on dietary factors in atherosclerosis, and on food additives; if your patients should ask about the safety of such additives as sodium propionate or monoammonium glutamate, you turn to page 467 to assure yourself that these chemicals are safe. Mr. Secretary Flemming's press releases on coal tar colors are mentioned, as well as the addition of antibiotics and hormones to animal feed and flesh. There is even a section on emergency, or disaster feeding, in case you have to head for the cellar.

All in all, a "commonsensical" and comprehensive book, marred somewhat by an inadequate index, typographical errors, and dated spelling. An over-all editing job would be helpful. The illustrations and paper stock are excellent, and there is a selected bibliography at the end of each chapter.

T. R. Van Dellen, M.D.

The Clonal Selection Theory of Acquired Immunity. Sir Macfarlane Burnet. $5.00. Pp. 209. Nashville, Vanderbilt University Press, 1959.

The mechanism of the formation of antibody, and therefore of acquired immunity, has occupied the attention of some of the best minds in biology and medicine. In this book Sir Macfarlane Burnet, one of the world's outstanding theoretical biologists, attacks the problem from a new standpoint, one influenced markedly by modern genetic concepts.

In the author's own words, the crux of clonal selection theory of immunity is "it assumes that in the animal there exist clones of mesenchymal cells, each carrying immunologically reactive

sites corresponding in appropriate complementary fashion to one (or possibly a number of) potential antigenic determinants. This provides a population of cells which, when an appropriate stage of development has been reached, are capable of producing the population of globulin molecules which collectively provide the normal antibodies. When an antigen is introduced, it will make contact with a cell of the corresponding clone, presumably a lymphocyte, and by so doing stimulate it to produce in one way or another more globulin molecules of the cell's characteristic type. The obvious way of achieving this is to postulate that stimulation initiates proliferation as soon as the cell in question is taken into an appropriate tissue niche, spleen, lymph node, or subacute inflammatory accumulation."

Space does not permit a detailed analysis of this theory nor a comparison with the several other current theories on antibody formation. It must suffice to say that the approach is timely and the reasoning lucid. Time and experimentation will determine the validity of the theory.

This volume has a value beyond the development of a new theory of antibody formation. There are beautifully written introductory chapters which cover the basic features of bacterial genetics and of immunology. Furthermore, in his discussion of the clonal selection theory the author provides informative chapters on immunological tolerance, mesenchymal cell function in immunity, the pathology of the immune response, proliferative diseases of the reticular tissue and mesenchymal cells, and neoplastic disease.

This book would be worth reading for the information alone; but when coupled with Burnet's theorizing, it becomes an exciting and provocative story that should be of interest to every biological scientist and physician.

Guy C. Youmans, M.D.

Your Heart: A Handbook for Laymen. H. M. Marvin, M.D. $4.50. Pp. 335. Garden City, N. Y. Doubleday & Company, 1960.

At least twenty books of this type have appeared in the last decade to answer the multitude of questions asked by the cardiac patient. Dr. Marvin's long service to the American Heart Association and his wide medical experience fit him to combine the details of medical understanding and research, tailored to the receptivity of the nonmedically trained individual.

A knowledgeable patient who read the book found it enlightening; it increased her perspective of heart disease and added to her medical vocabulary. She felt that reading the book would relieve her anxieties about heart disease, but thought the details were somewhat excessive, even redundant.

The author includes rare conditions such as the carcinoid syndrome and arachnodactyly in a discussion that can mean little to the layman. Dr. Marvin devotes too much space to controversial subjects. Specificially, the controversy regarding the "arm-chair treatment of coronary thrombosis" has been relegated to a legal problem, wherein the doctor is alleged to omit it simply because of fear of legal action. Most patients would prefer to believe that the physician makes a decision on the basis of what he thinks is best for the patient rather than from fear of legal restraint. Why promote malpractice consciousness in the public when it is already on the increase?

A whole section is devoted to the anticoagulant controversy. Since trained cardiologists still debate the problem, the layman should not be expected to resolve it for them from the detailed statistical reports included in this text. Dr. Marvin may believe that open heart surgery will replace closed heart operations, but the statement could produce ungrounded criticism of a capable physician who advocates the older and, in many instances, safer closed procedures where applicable.

There is an excellent glossary with succinct definitions and references to the medical terms used by physicians, and an appendix listing booklets and leaflets obtainable from local Heart Associations. The author publicizes the significance of the Heart Association in providing education and research dedicated to practical patient care.

William H. Wehrmacher, M.D.

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REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

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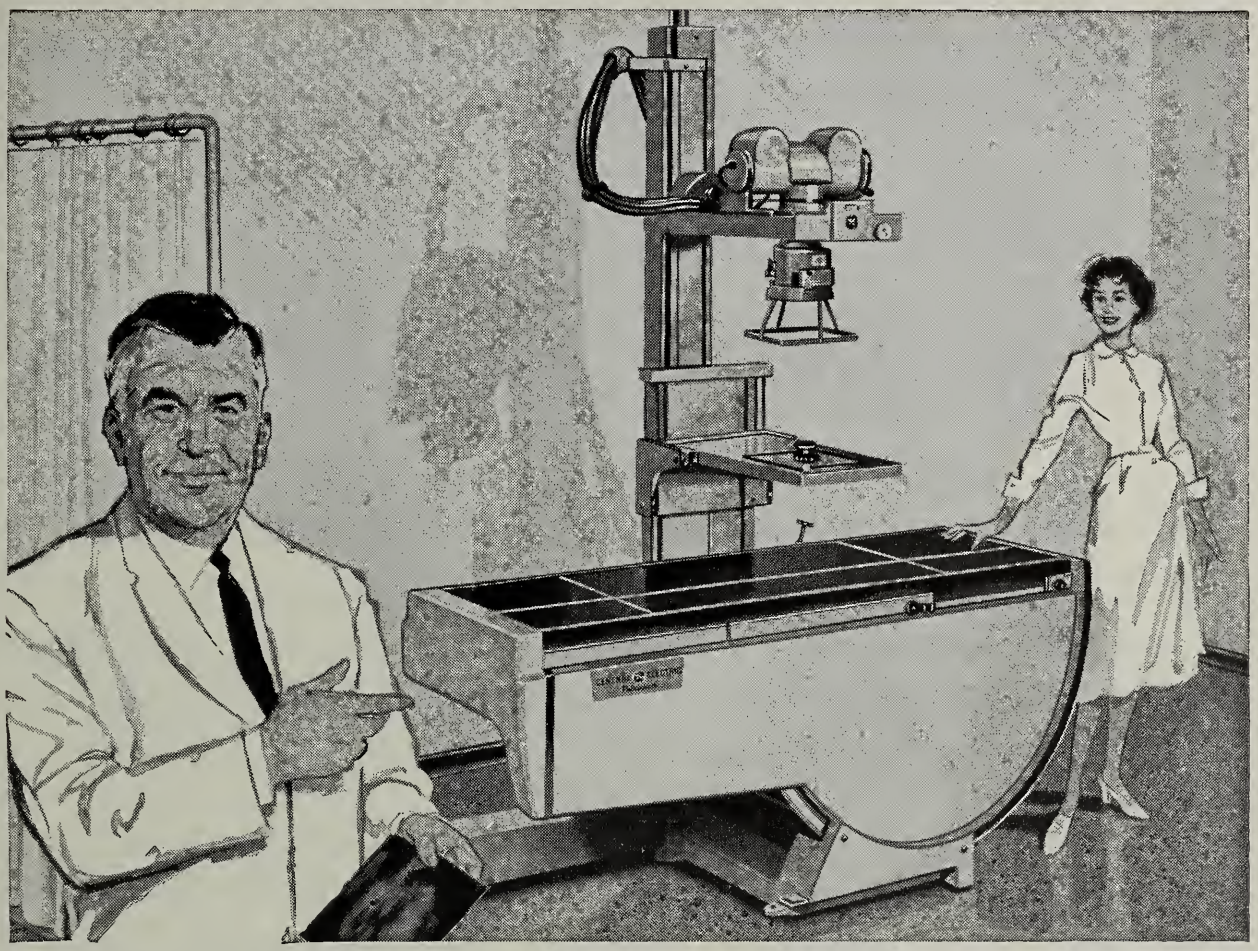
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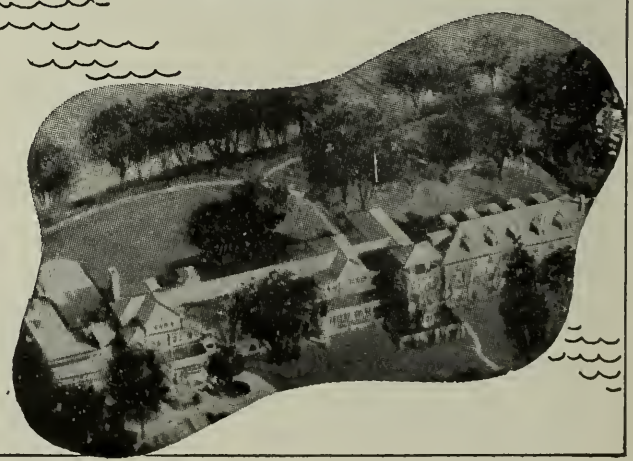
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Early cancer of the prostate

Approximately 12,000 men die each year from prostatic carcinoma; yet in about 90 per cent of the patients this malignancy begins in the area of the prostate that is palpated at the time of rectal examination. Strangely enough, only 5 to 10 per cent of the patients with carcinoma of the prostate are referred to the urologist early enough so that radical surgery can be attempted. There are two possible reasons for this: Not enough periodic examinations are done on men over the age of 45 years, and physicians are not completely familiar with the digital characteristics of early carcinoma of the prostate.

In performing rectal examination of the prostate, not only is the size of the gland of interest, but more important is the presence or absence of a localized area of nodularity or increased density. These lesions are nontender. There does not have to be a palpable nodule raised above the surface of the gland in order for early carcinoma to be present. The centimeter-sized area of increased density within the gland may well represent a cancer. Neither the nodule nor the localized area of increased density need be as firm as a stone, but simply firmer than the adjacent gland.

Any nodule or area of increased density in the prostate gland of a man over 45 years of age is cancer until proved otherwise. To ignore this elementary principle is often disastrous. In order to obtain proof of diagnosis, the next step is biopsy of the suspicious area. Exfoliative cellular cytologic studies on urine or the prostatic secretion have not been too effective. The early lesions are situated too far posteriorly in the gland to exfoliate malignant cells into the urethra for efficient detection when it is most needed. *Roger Baker, M.D. Value of Periodic Examinations in Detecting Cancer of the Genitourinary System. Postgraduate Medicine. March 1960.*

Every right has its responsibilities. Like the right itself, these responsibilities stem from no man-made law, but from the very nature of man and society. The security, progress and welfare of one group is measured finally in the security, progress and welfare of all mankind.

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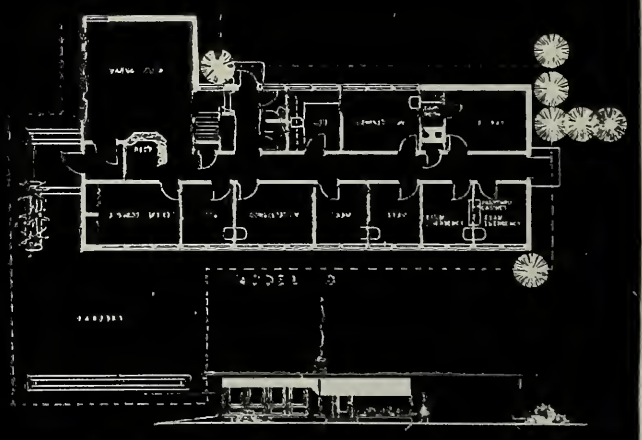
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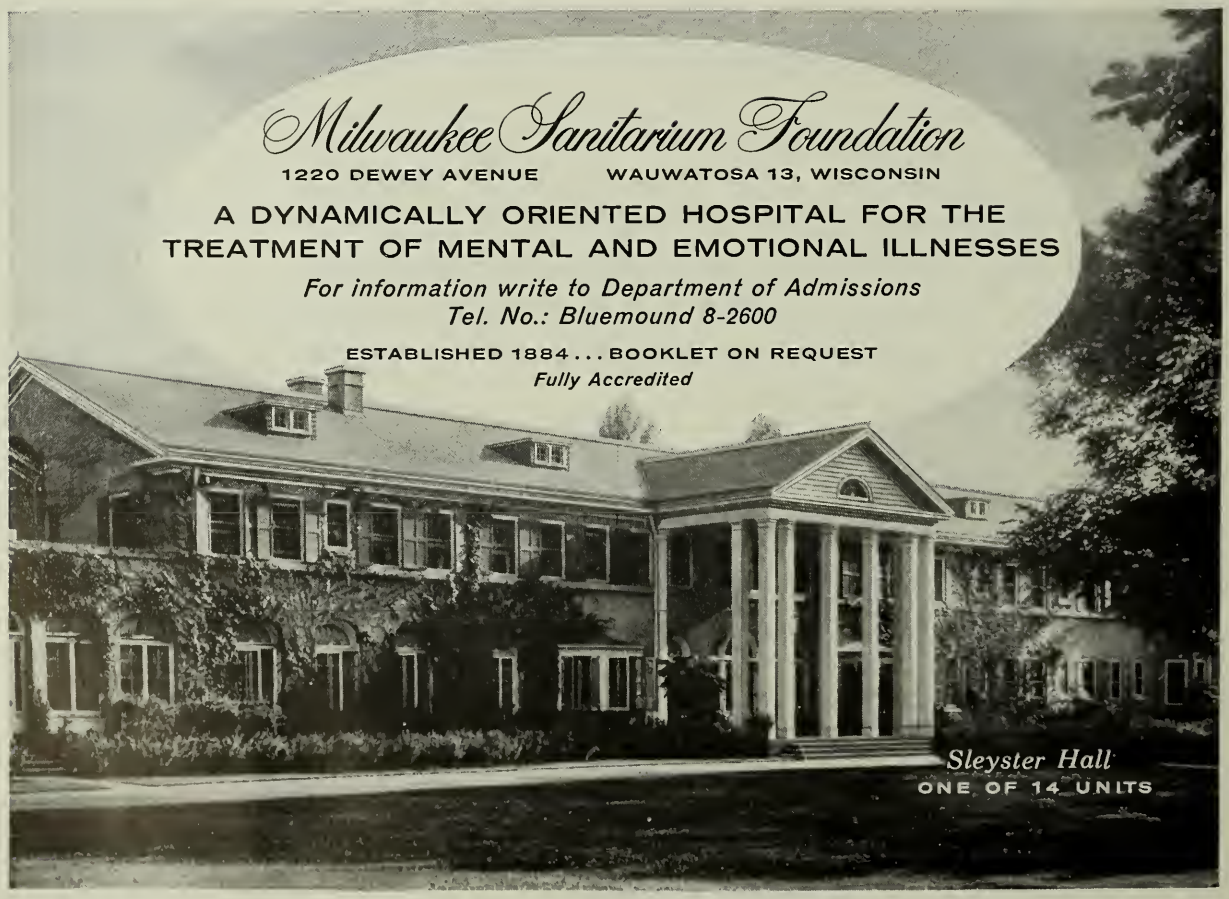
A hormone therapy evaluation

Each of 12 elderly women with post-menopausal osteoporosis, including one with Paget's disease, serially received an estrogen, a florinated androgen, an inert placebo, and a psychopharmacologic stimulant given as an active placebo. Evaluation was carried out on a double-blind basis and included measurement of the objective effects of each agent on the osteoporotic process—calciuria and calcium dynamics determined by a strontium tracer technic—and on the psychologic status—subjective response, including vertebral pain, cognition, motor performance, and social function.

The urinary excretion of endogenous calcium and of exogenous strontium were reduced equally by each of the sex steroids. Pain was reduced during administration of the estrogen but almost as effectively by the inert placebo. Pain was actually worse during therapy with the androgen. Despite improvement in mineral metabolism, estrogen produced no greater improvement than the placebos on other subjective end points, and the androgen actually lessened the sense of well-being as assessed by patient, observer, and psychologic tests. Previously reported beneficial effects of sex steroids on cognition in elderly women were not confirmed, possibly because of the short period of treatment. Likewise, motor performance and general ability to function were not altered by any of the medications. The pattern of individual response seemed related to personality structure, the compulsively driven patient being less changeable than the person with freer affect. *George F. Solomon, M.D., William J. Dickerson, M.D., and Eugene Eisenberg, M.D. Psychologic and Osteometabolic Responses to Sex Hormones in Elderly Osteoporotic Women. Geriatrics. Jan.* 1960.

There's no thrill in easy sailing when the skies are clear and blue, there's no joy in merely doing things which any one can do. But there is some satisfaction that is mighty sweet to take, when you reach a destination that you thought you'd never make.

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A study in contrasts

The London medical student outwardly exhibits a determination not to be overwhelmed by work — the result, it is claimed, of his intensive, somewhat monastic, preacademic and living freedom, and it is understandable that at first he takes advantage of this heady new environment. In contrast to a large proportion of medical students in the United States, only a few London preclinical students are burdened with the blessings (?) of matrimony and parenthood.

Because British secondary education lays stress on command of the written word, the London student's examination answers are, compared to those of his American counterpart, prose masterpieces. One can hardly overstate this difference in skill of written communication. In class discussion, however, the Londoner tends to be tongue-tied and shy. He is terribly afraid of making an ass of himself or showing off. It is evident that his inhibited performance is confined to the classroom, since informal social meetings, flavoured by suitable liquid refreshment, reveal him to possess a positive talent for oral expression. He is likely to be fluent on all topics other than those connected with his studies. *Arnold H. Schein, B.S., Ph. D. Preclinical Biochemistry. The Lancet. March 26, 1960.*

General vs hospital practice

There is no gainsaying the fact that for many young medical people a career in general practice is a last refuge. It is something to be avoided if possible, even at the cost of poorly rewarded years of frustration in junior hospital posts endured in the dwindling hope that a permanent career in hospital will somehow turn up to obviate the necessity for taking the degrading downward step into general practice.

That this attitude should exist is quite tragic, for family practice ought to be, and be known to be, the most spiritually rewarding form of medical practice. Let us not shut our eyes to the fact that there is plenty of bad medicine in general practice and plenty also in hospital practice. The profession is composed not of paragons and saints exclusively, but of ordinary fallible mortals. *G. M. Hamilton, M.B. Wrong Turnings in the N.H.S. Brit. Med. J. Jan.* 23, 1960.

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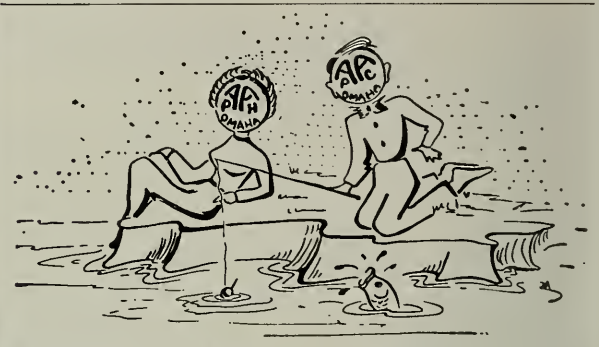
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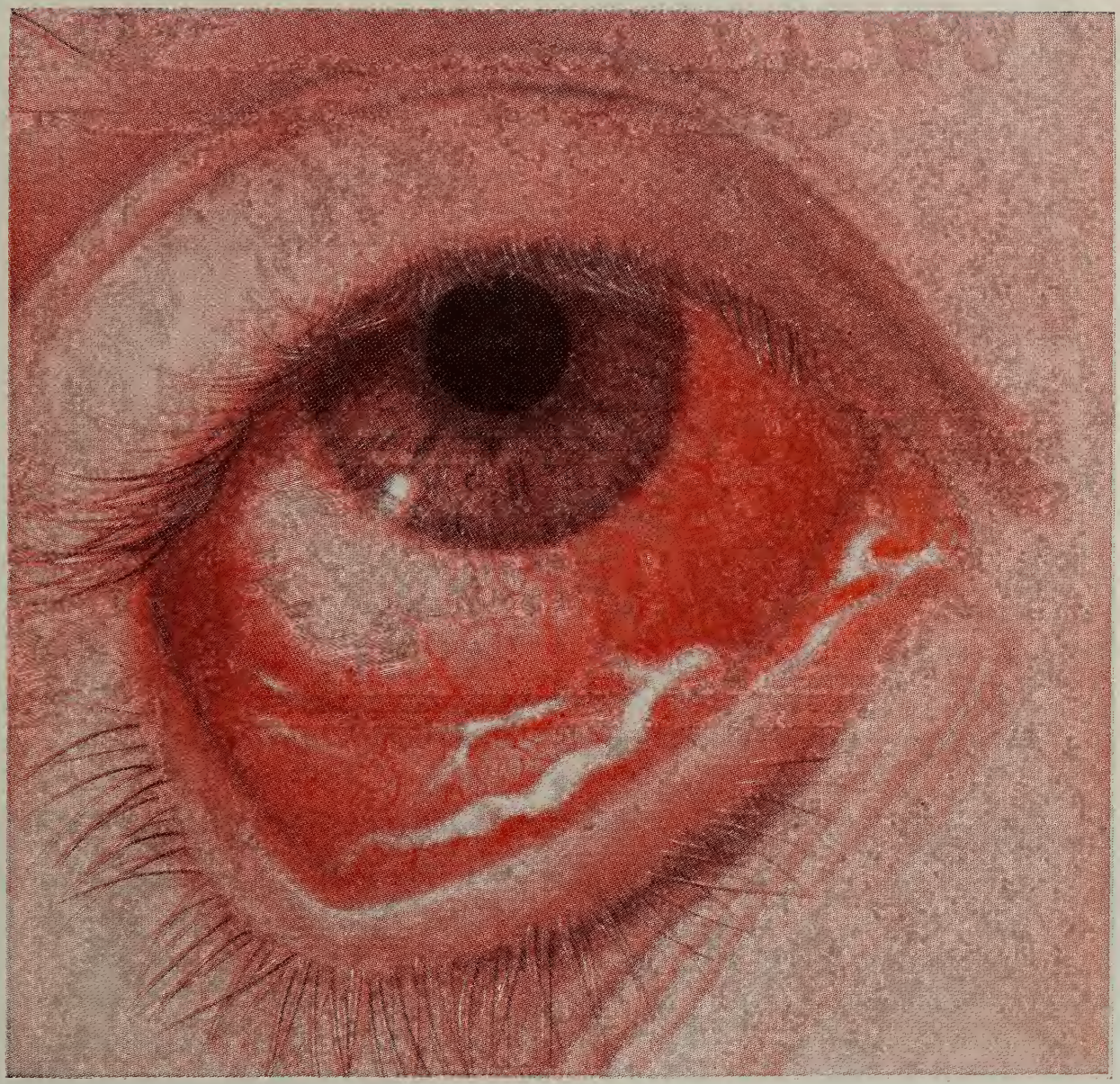
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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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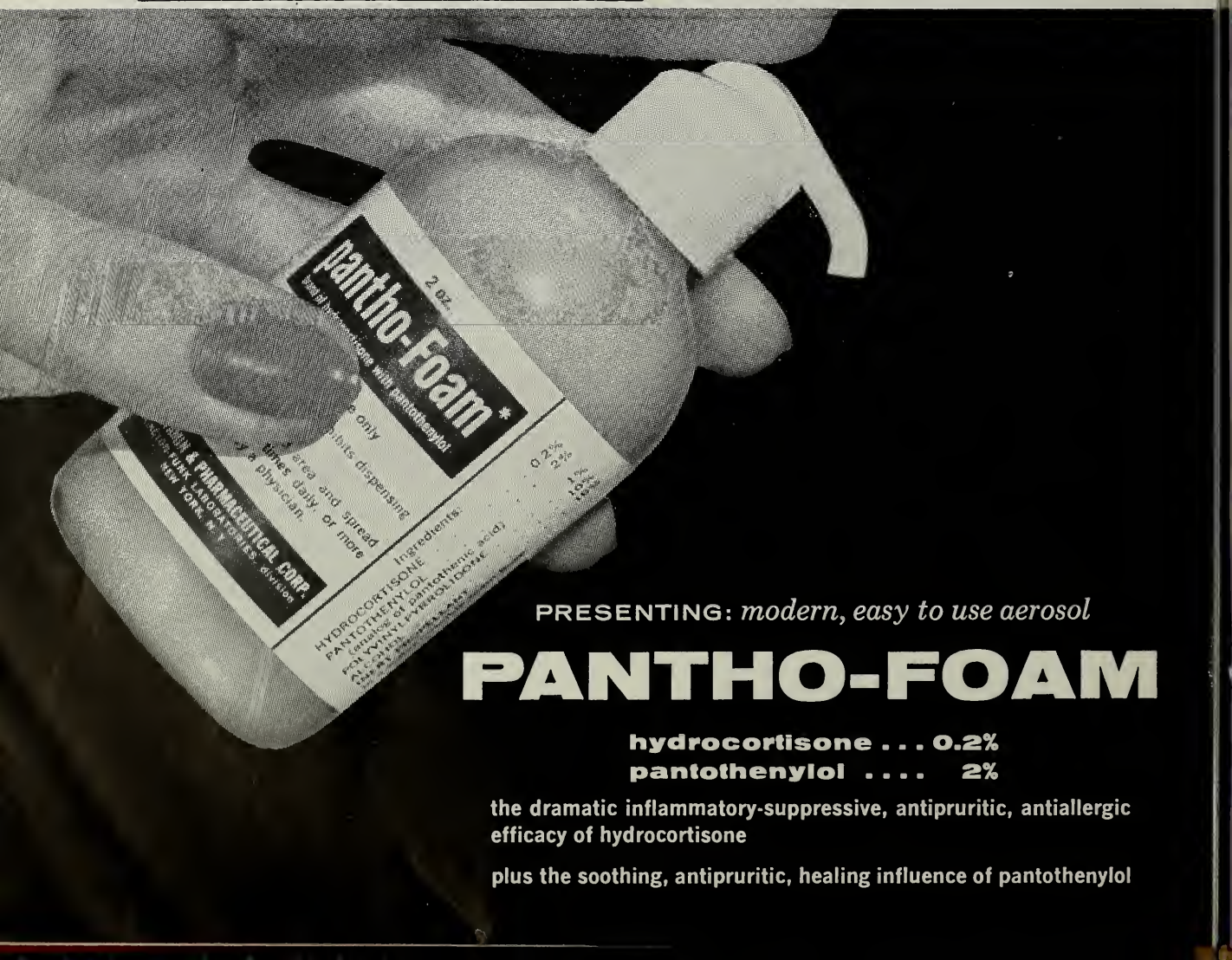
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Our means for attacking some of the problems of mental health in the aged are by no means negligible. We need to intensify scientific inquiry into the wide variation in the extent to which faculties decline and to which old age is burdened with illness among individuals in the same and different social groups. All disciplines have a part to play in this quest: genetic, physiological, epidemiological, sociological, and psychiatric. Meanwhile a great deal could be achieved through a better utilization of existing knowledge of the medical and social aspects of mental health in old age; the promotion of physical well-being in early life; the application of greater imagination to, and the consultation of, the human beings affected by community development; the attack on loneliness and isolation; and the early discovery, diagnosis, and treatment of physical and mental illness among the aged, with recognition of the early signs, particularly of depressive illness and suicidal risk. Those who have made suicidal attempts, so often determined and successful among the aged, could be given more ade-



quate rehabilitation and after-care. I shall not add to the volume of words spoken on the need for integrating the different agencies involved in the care of the aged beyond saying that we are not likely to progress far beyond pious platitudes until a sincere attempt is made by all the persons concerned to place the needs of the aged individual far above all administrative consideration. *J. H. Sheldon, M.D. Problems of an Ageing Population. Brit. Med. J. April* 23, 1960.

Doing for people what they can and ought to do for themselves is a dangerous experiment. In the last analysis, the welfare of the workers depends upon their own initiative. Whatever is done under the guise of philanthropy or social morality which in any way lessens initiative is the greatest crime that can be committed against the toilers. Let social busybodies and professional "public morals experts" in their fads reflect upon the perils they rashly invite under this pretense of social welfare.

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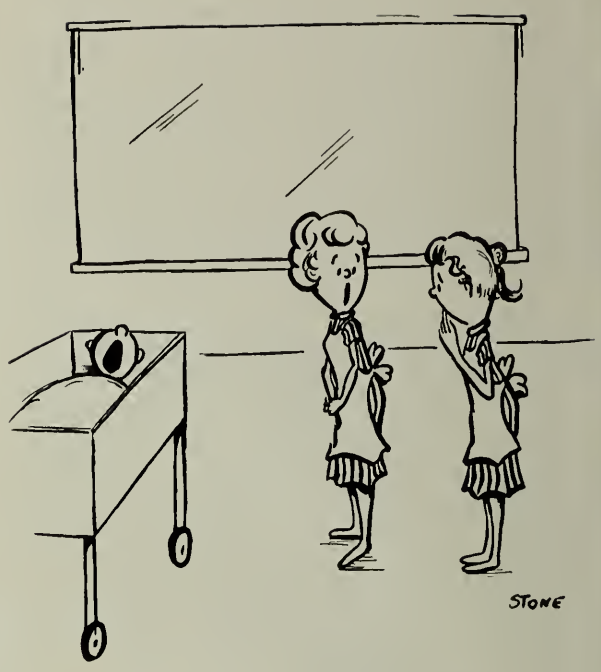
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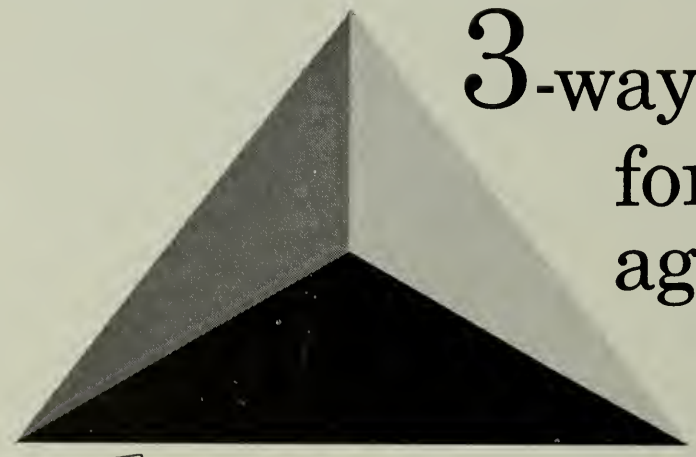
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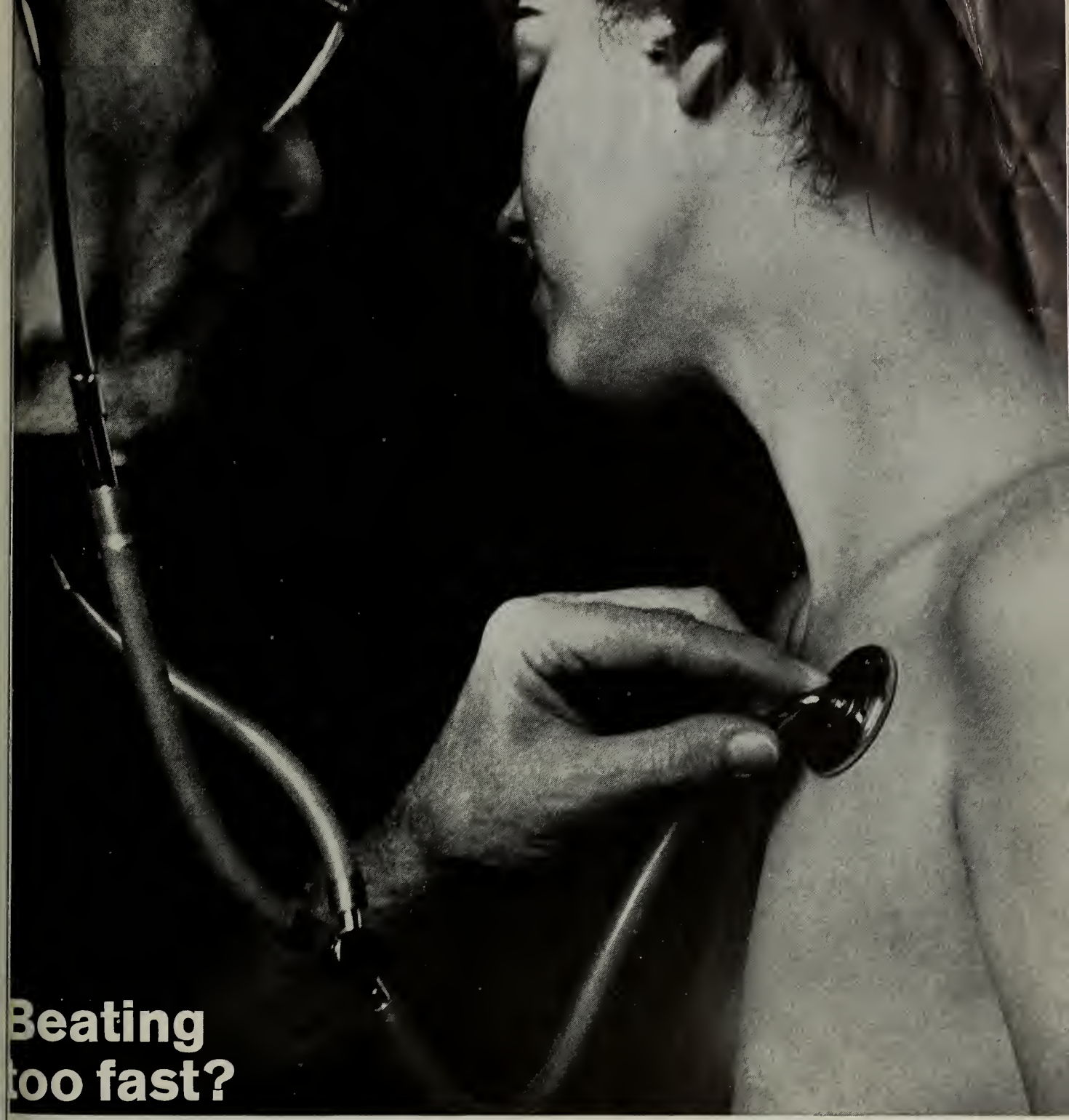
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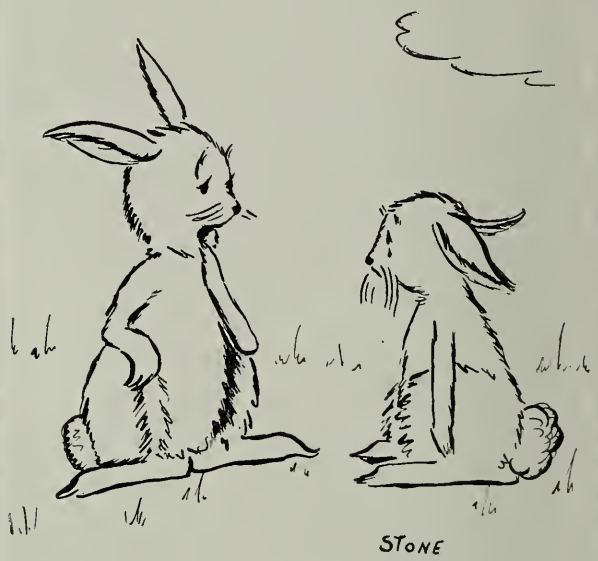
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Somatic vertigo

I know of some older patients who dare not go outside their homes alone, lest they be stricken by vertigo. These cases are illustrative because all had gone through otologic and neurologic investigations repeatedly and without any pathologic findings. The interview clearly brought out that these people were never dizzy at home or when outside with a relative or friend. I know of no somatic affliction that shows its symptoms outside of the home exclusively! One of them could leave his house only when he had a token friend with him—his bike or his car. He was an excellent driver, but outside his car dizziness promptly set in. Such a symbolic expression of dependency-need is usually rooted in extreme infantile trauma and can be the expression of a latent psychosis. *Joost A. M. Meerloo, M.D. Dizziness and Our Dizzy World. Am. Pract. & Digest Treat. March 1960.*

An ideal is the most practical thing in the world, for it is a force behind action that must be reckoned with by the frankest materialist.

— Edward H. Griggs

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1. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960.

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The Month in Washington



Congress returned to work this month to take up its unfinished business, including the controversial issue of health care for the aged in an atmosphere dominated by election-year politics.

The three or four week, tag-end session of Congress loomed as one of the most important meetings in the past decade as far as possible impact on the medical profession is concerned.

The lawmakers are slated to decide whether to embark the Federal government on a course that could threaten the private practice of medicine, or to adopt a voluntary program that would pose no such danger.

The omnibus social security bill approved by the House Ways and Means Committee was easily cleared by the House, 381 to 23, and sent to the Senate Finance Committee, which held two days of hearings. The measure contained a voluntary, Federal-state program for assisting needy aged persons to meet health care costs. Both the administration and the American Medical Association endorsed the House measure as in keeping with the concept of giving the states prime responsibility for helping their citizens, for aiding those who are most in need of help, and for avoiding the compulsory aspects of health plans involving the social security mechanism.

A vote by the Finance Committee, headed by Sen. Harry F. Byrd (D., Va.), was scheduled for shortly after the Senate resumed operations in August. Whatever action the Committee took, however, proponents of schemes such as the Forand Bill to provide a compulsory, Federal medical program promised a determined fight on the floor of the Senate.

In the event Congress should approve a government medicine plan, opponents were counting on a Presidential veto to kill the measure. The Chief Executive repeatedly has asserted in strong language his all-out opposition to any compulsory plan for health care financing.

At the Senate Finance Committee hearing, Arthur S. Flemming, Secretary of Health, Education and Welfare, renewed the Administration's flat stand against the social security avenue to financing health costs. Such a plan, he said, would inevitably lead to pressures for expanding the benefits and lowering or eliminating the age requirement. Under such circumstances, a 15 per cent or 20 per cent social security payroll tax would not be too far off, he said. "We believe it is unsound to assume that revenue possibilities from a payroll tax are limitless."

Dr. Leonard W. Larson, president elect of the American Medical Association, told the Committee the House bill is the "antithesis of the centralized, socialized, statist approach of the proposals advocating national compulsory health insurance. To those critics who call this program modest, we say that fiscal irresponsibility, unpredictable cost and maximum nationalization are not the accepted criteria for good legislation," he testified.

A spokesman for the insurance industry

(*Continued on page* 24)

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WASHINGTON (Continued)

pointed out "giant strides" made by private health insurance in recent years in covering aged persons. E. J. Faulkner declared that one of the most prevalent and erroneous assumptions on the matter is that most of the aged aren't able to contribute to financing their own health care costs.

The social security health bills, he said, "would impair or destroy the private practice of medicine, would add immeasurably to our already crushing tax burden, would aggravate our severe public fiscal problems, and would entail other undesirable consequences."

In other testimony, the AFL-CIO again urged enactment of a social security health bill; the American Optometric Association and the International Chiropractors Association urged that health benefits included in any bill include the services of osteopaths and chiropractors, respectively.

On another legislative proposal of interest to the medical profession—the Keogh-Simpson Bill—a Senate debate was scheduled this month. Sen. Gordon Allott (R., Colo.) said in a Senate speech, "I believe that this legislation will have the overwhelming support of this body."

The bill, which would encourage retirement savings by the self-employed such as lawyers, small businessmen and physicians, has already been approved by the House. The Senate bill, voted by the Senate Finance Committee, would require participating self-employed to establish retirement plans for their employees.

Not for the timid

One of the tragedies of our time is the manner in which the American people have been psychologically frightened over the past decade by the horror-dramatization of all-out nuclear war, and have been led to regard that threat as more terrifying or more imminent than defeat through a series of limited politico-military setbacks. Tragic also is the manner in which Americans have been led to believe that if they appropriated enough money, their thorny security problems would somehow be solved by others, who had come upon a neat, fool-proof formula for victory. *Rear Admiral George H. Miller, USN, "Not for the Timid." U.S. Naval Inst. Proc. May* 1959.

The
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AUGUST, 1960
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Tuberculosis Chemoprophylaxis*

Edward A. Piszczek, M.D. M.P.H.† *Chicago*

Tuberculosis survey programs began in Chicago in 1936 with the use of 14 by 17 x-ray films. In 1940 the first 4 by 5 films were used, and in 1948 the use of 70 mm. film was begun. The purpose of the survey program during that time was to discover the active cases of tuberculosis and place them under clinic management. At that time there were inadequate beds in our tuberculosis control facilities, and the surveys were conducted with the hope of detecting the early cases of tuberculosis and placing them under home treatment.

Early records of the productivity of the surveys are not too definite. All of the abnormal chest films were read primarily as suspect films because the roentgenologist was interested in recognition of the active case of tuberculosis. No attempt was made in those early surveys to record old apical or other area scars found on these films. Because of the limited amount of survey work done, confined primarily to immediate contacts of known cases and to the areas of population with high incidence of disease, it was not unusual in those days to find two, three, or even four active cases of tuberculosis per 1,000 survey films. With more than 10 million persons surveyed by x-ray in Cook County in the last fifteen years, the percentage of active cases of tuberculosis found as a result of the surveys has greatly decreased. The figures for the year 1959, covering 1,005,275 readable survey films, indicate that approximately

97.4% of the films were read as negative
0.9% were read as suspect tuberculosis
1.0% were read as suspect cardiac abnormalities
0.7% were read as suspect other pathologic abnormalities.

Today, in public health practice, x-ray surveys of the chest are carried on in the population areas with high incidence of the disease. The

*From the clinics of the Suburban Cook County Tuberculosis Sanitarium District, Forest Park.

†Field director, The Suburban Cook County Tuberculosis Sanitarium District; clinical professor and chairman of the department of preventive medicine and public health, Stritch School of Medicine, Loyola University.

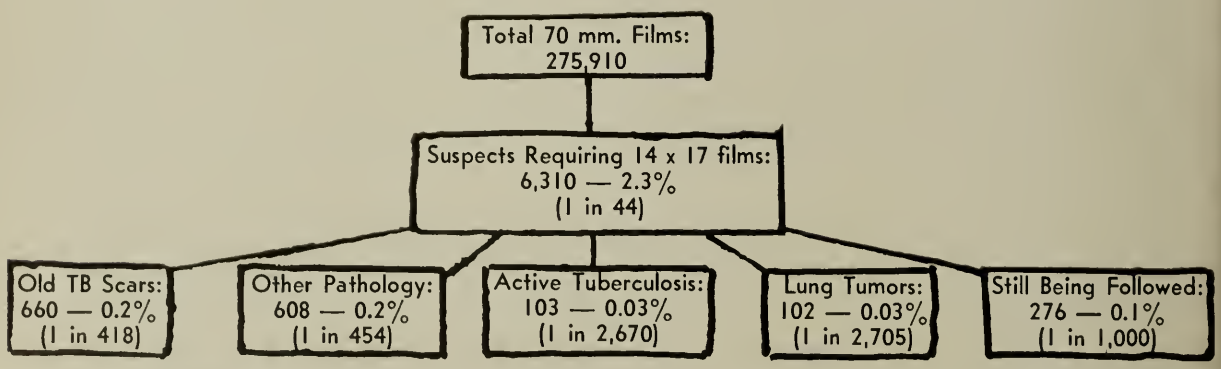
finding of new active cases of tuberculosis as a result of surveys has diminished considerably. Today, the roentgenologist who reads survey films is not looking for active tuberculosis alone but is concentrating on all abnormalities of the chest, including old tuberculosis scars, tumors, cardiac size and anomalies, and diaphragmatic lesions.

The modern Fairchild Odelca 70 mm. camera equipment in addition to supersensitive green film produces a very superior type of miniature x-ray much improved over the early 4 by 5 or 70 mm. x-rays.

The Suburban Cook County Tuberculosis Sanitarium District serves approximately 1,200,000 people living in the suburbs of Cook County outside the city of Chicago. This suburban population is slightly above average in housing, economics, and living conditions. The percentage of city-like slums is very low, and the total population of the minority groups would probably not exceed 10 per cent.

Major findings on chest films

During the year 1958, 275,910 survey films were taken. The following chart indicates the major chest findings in this survey after one year follow-up on all suspicious films:



Of the 275,910 persons having 70 mm. x-rays taken during 1958, 6,310 or 2.3% (1 in 44) were asked to come back for a larger 14 by 17 film. By some this percentage is regarded as slightly higher than normal. However, the surveys are conducted throughout the year, including peak periods of influenza incidence as well as the periodic epidemics of the upper respiratory infections and waves of viral pneumonitis; during these periods the number of abnormal findings on the x-rays, because of acute pneumonic infiltrates, is higher than the normal average.

Within one year after the x-rays were taken, 103 or 0.03% (1 in 2,670) persons were found to have active tuberculosis. Eighty-one of these patients were immediately hospitalized; 22 others were treated on an out-patient basis because of early discovery of the disease.

Of the 103 active cases of tuberculosis found, 37 (35.9%) were in the minimal stage, a total of 45 (43.7%) in the moderately advanced stage, and 20 (19.4%) in the far advanced stage. One additional case of tuberculosis activity was found in the primary pulmonary stage. This is an exceedingly high percentage of primary, minimal, and moderately advanced cases, totalling 80.6 per cent. Discovery of tuberculosis in these early stages of disease pays exceedingly high dividends not only in early and effective treatment but in complete rehabilitation.

One of the side benefits of roentgenologically reading all findings on miniature chest x-rays was 660 or 0.2 per cent (1 in 418) persons found with old tuberculosis scars. These persons when found on suspect films are requested to come to our medical clinic for large 14 by 17 films and tuberculin skin-tests. The x-ray follow-up may be done at monthly, bimonthly, or quarterly intervals for a period of at least one year to insure x-ray stability before a diagnosis of healed old tuberculosis scars is made. Most of the individuals with this diagnosis are immediately placed under isoniazid chemoprophylaxis.

A total of 608 persons, 0.2 per cent (1 in 451), were found with other pathologic conditions, and each was referred immediately to his family physician after explanation of the x-ray

findings to the patient. A report of the x-ray findings, plus the film, was supplied to the family physician.

A total of 102 or 0.03 per cent (1 in 2,705) were found with lung tumors. These patients were referred to the family physicians who in turn referred them to chest specialists for further consultation, evaluation, and, many times, surgical intervention. It is much too early to evaluate the follow-up of these 102 lung tumor cases, but from preliminary reports of surgery and follow-up, between one-fourth to one-third of the tumors were found in an early stage when surgical removal might be helpful. But more than 50 per cent of lung tumors diagnosed were already in the inoperable stage, and their presence in most instances unknown to the patient.

A total of 276 persons, 0.1 per cent (1 in 1,000) were still being followed by our clinic staff one year after the x-rays were taken. Most of these persons have had at least four x-ray films, and the clinicians will still report unstable x-rays. The patients had been completely worked up with tuberculin test, in some instances bronchoscopy, sputum smear, and culture examination; many, after several months' observation, were placed under isoniazid chemoprophylaxis.

One may question the economics behind such a mass survey program. It is estimated that the cost of using 70 mm. films in such surveys would amount to approximately 75 cents per film. One can easily determine from the statistics given the approximate screening cost of finding an active case of tuberculosis, an old case of tuberculosis, lung tumors, or other pathologic conditions of the chest.

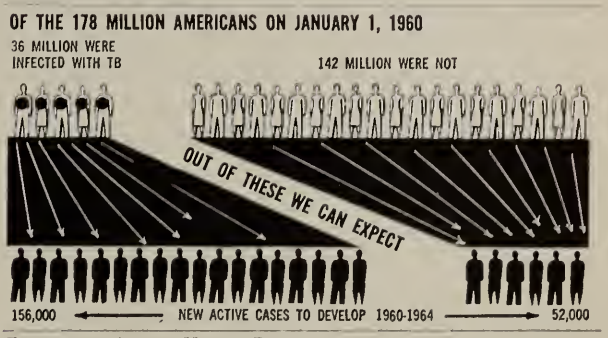
In the opinion of our staff, this case-finding program, which finds approximately one-third of all of our new active cases by mobile surveys, is highly productive for not only active tuberculosis but for old scars of tuberculosis and other pathologic conditions of the chest.

Tuberculosis chemoprophylaxis

The drug isoniazid, introduced in 1951 for the treatment of tuberculosis, has proved to be the drug of choice. Its low cost and low toxicity make it ideal not only for treatment of active tuberculosis but for a program of tuberculosis chemoprophylaxis aimed toward tuberculosis eradication.

The Arden House Conference of the United States Public Health Service and the National Tuberculosis Association, held Nov. 29 to Dec. 3, 1959, in planning for the control and ultimate eradication of tuberculosis, has in its program the continued use of isoniazid in chemoprophylactic studies.

ORIGIN OF FUTURE TB CASES



FROM THE ARDEN HOUSE REPORT

The conference outlined the origin of future tuberculosis cases in the United States during the next five years— 1960-64. Of the 178 million Americans on Jan. 1, 1960, 36 million were infected with tuberculosis, as evidenced by a positive tuberculin test and other findings. One hundred and forty-two million had a negative tuberculin-test status. Out of the 36 million tuberculin-positive individuals, 156,000 are expected to be new active cases during the next five year period—three times the number, or 52,000, that are expected to develop among the 142 million negative-tuberculin individuals.

According to the Arden House report, "Most new cases will come from people now infected. The 20 per cent of our nation's population estimated to have been infected with TB baccilli sometime in the past will contribute three out of four of the new cases in the next few years. The rest will come from people not now infected. The implications for TB control, especially the need to discover tuberculin reactors and investigate their contacts, are clear" as evidenced by the following chart:

The value of isoniazid for children has been extensively demonstrated in many studies conducted in the United States. In our district program the use of isoniazid as a prophylactic agent was first extended to children under the age of 3 with a positive tuberculin reaction. Soon afterward the program was extended to all chil-

dren under the age of 5 with contacts to know cases, then to the age of puberty; and now our staff places no age restrictions on participation in isoniazid prophylaxis studies for persons with positive tuberculin tests.

During the past several years, several thousand residents of suburban Cook County who had suspicious x-ray findings in the chest x-ray survey program were called in for large x-ray films and medical consultations. They were clinically followed by study of the tuberculin tests, sputum smears and cultures, and repeated x-ray examinations. When found to be tuberculin-positive and with highly suspicious old tuberculous scars, these patients were placed under isoniazid prophylaxis—the children on a dosage of 5 to 10 mg. per Kg. of body weight daily, and adults on an average dose of 100 mg. three times a day. During the past three years more than 2,000 individuals have received one year of chemoprophylaxis.

In our studies we have not seen any case started on isoniazid prophylaxis that has eventually developed into an active case of tuberculosis. A number of children were started on isoniazid prophylaxis because they were direct family contacts to a known case, despite the fact that they had a negative tuberculin test. In a six-month or one-year follow-up, a number of children converted from negative to positive, but without evidence of clinical tuberculosis.

An international program of this dimension could prove very effective in totally eradicating tuberculosis in the upper age groups.

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Footnotes and references should conform to the following style in the order given: Name of author; title of article; name of periodical; with volume, page, month — day of month if weekly — and year. The Illinois Medical Journal does not assume responsibility for the accuracy of references used with scientific articles.

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The Current Status of Tuberculosis In Chicago

E. Lee Strohl, M.D.* *Chicago*

The board of Directors of the Municipal Tuberculosis Sanitarium is charged with prevention and treatment of tuberculosis within the city limits of Chicago, where approximately 70 per cent of all patients with tuberculosis in the state reside. Statistical evidence from other large metropolitan centers in the United States reveals a similar incidence.

The Municipal Tuberculosis Sanitarium has 1,143 beds at 5601 North Pulaski Road, 208 beds in the North Riverside branch, and 90 in the pediatric section of the Municipal Contagious Disease Hospital — a total of 1,441 beds; 300 beds are available to Chicago residents at the Chicago State Tuberculosis Sanitarium. Currently, 90 per cent are occupied.

At five clinics maintained by the Municipal Tuberculosis Sanitarium, prophylactic and medical treatment is provided on an out-patient basis.

Long range program

In 1949, to meet changing community needs, the Municipal Tuberculosis Sanitarium launched a long range program in the prevention and treatment of tuberculosis. With support of the Chicago Medical Society, the Tuberculosis Institute of Chicago and Cook County, the Institute of Medicine of Chicago, and other interested medical and civic groups, financial subsidy was obtained from the state legislature. Subsequent legislatures have provided necessary finances associated with the expanded services.

Since the School of Affiliation in Tuberculosis Nursing was opened in 1950, 16 schools of nursing from Illinois, Indiana, Wisconsin, and Iowa send about 60 students to each six-week session.

In 1959 more than 400 students completed their affiliation in tuberculosis nursing there.

In 1951 the North Riverside branch was rehabilitated, one building being remodeled for occupancy by bed patients.

In 1952 the Mayor's Advisory Committee on Tuberculosis was created. The following medical organizations are represented on this committee: Chicago Medical Society, Board of Health, Institute of Medicine of Chicago, Tuberculosis Institute of Chicago and Cook County, and Cook County institutions. The following lay organizations also are represented: the State Legislature, the City Council, the Association of Commerce and Industry, labor organizations, the Welfare Council of Metropolitan Chicago, and the Civic Federation.

The value of chemotherapy was demonstrated in 1952 by a pilot study of out-patients. Physical changes in clinics and indoctrination of medical and nursing staff in new procedures were necessary to provide the new treatment. It is notable that there was a waiting list of 602 patients at the Sanitarium on Jan. 1, 1953. Because chemotherapy in all clinics permitted earlier discharge from the Sanitarium and more efficient use of beds, this backlog of admissions decreased to zero by August, 1954. There is no waiting list for admission to the sanitarium at this time.

In 1953, through the cooperation of the Chicago Board of Health, two floors of the Municipal Contagious Disease Hospital were obtained for pediatric patients below twelve years of age.

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*President, Board of Directors, Municipal Tuberculosis Sanitarium.

Presented at 10th Annual Spring Conference on Tuberculosis, The Tuberculosis Institute of Chicago and Cook County, March 16, 1960.

Ninety beds have been maintained and occupied since that time. The Chicago Board of Education provides kindergarten and grade school teachers for children under treatment.

X-ray program extended

A chest x-ray program for inmates of the House of Correction was begun in 1954 and shortly thereafter a similar program at the Cook County Jail. Through the cooperative efforts of the Tuberculosis Institute of Chicago and Cook County, and the Cook County authorities, patients with tuberculosis are isolated and treated.

While there has been a significant reduction in the suspect rate in the general population through the Mass X-Ray Survey, there has been little change in the suspect rate of those entering the House of Correction and Cook County Jail.

Another milestone was passed in 1954, when the Chicago Board of Health passed regulations requiring chest x-rays of all food handlers in the city. Today we process about 150,000 chest x-rays annually on this group of people.

The State Legislature in 1955 passed a law requiring school employees to be free of active tuberculosis. Joint mass survey facilities of the Municipal Tuberculosis Sanitarium and the Tuberculosis Institute of Chicago and Cook County were made available for this testing program.

The Lake View Clinic was opened in 1956. It combined the previous Damen Avenue and the Municipal Tuberculosis Sanitarium-Swedish Covenant Hospital clinics. The clinic was designed to care for the indicated increase of patients for chemotherapeutic treatment of tuberculosis.

In 1957, through the cooperation of the judges of the Municipal Court and many social agencies, a program of assistance, control, and treatment of tuberculosis for patients in the Skid Row area was established. The alcoholic problem and tuberculosis control have been shown to be very closely related. These patients are seen primarily in the Monroe Street Court.

An infant prophylactic program was begun in the Municipal Tuberculosis Sanitarium clinics in 1957. Chemotherapeutic agents are now being given to children under four years of age who have been in contact with a patient having active tuberculosis.

During the last year, those Chicago residents with tuberculosis who were in the Cook County Oak Forest Hospital were transferred to the Municipal Tuberculosis Sanitarium for treatment. Residents found to have tuberculosis at the Cook County Hospital are now referred to the Municipal Tuberculosis Sanitarium for follow-up and treatment.

In 1958 the Board of Directors acquired property at 3525 South Michigan Avenue for a new clinic that was occupied in 1959. It consolidated the Municipal Tuberculosis Sanitarium-Provident Hospital and Municipal Tuberculosis Sanitarium-Mercy Hospital clinics.

We are aware that the incidence of tuberculosis is being reduced. However, Chicago is a dynamic city. Thousands of in-migrants from rural areas flock to its industry. Unaccustomed to problems of living in large metropolitan areas, they are easily and quickly victims of tuberculosis. We will feel the impact of these in-migrants for many, many years.

We are not satisfied with the progress that has been made. We hope to improve the present high standards of medical, surgical, and nursing services in all areas of the Municipal Tuberculosis Sanitarium. The Board of Directors is constantly reviewing methods to improve the prevention and the treatment of tuberculosis.

It is our sincere wish that support and cooperation of all organizations—medical, governmental, and civic—which has been given so generously in the past will continue.

In the following tables, 1 through 5, statistical data is given to show trends in treatment of the disease.

TABLE 1.—Tuberculosis Cases and Deaths of Chicago Residents

	New Active Cases Reported		Deaths By Occurrence*		Deaths By Residence†	
Year	Number	Rate	Number	Rate	Number	Rate
1955	4218	112	491	13.0	629	17.0
1956	3841	101	439	11.7	539	14.6
1957	3623	94.6	405	10.8	488	13
1958	3094	81.3	377	9.7	476	12.7
1959‡	2785	71.7	330	8.5	Not available	

*Deaths by Occurrence includes all deaths from tuberculosis in Chicago. Annually about fifteen non-Chicagoans die from tuberculosis in the city.

†Deaths by Residence includes all Chicagoans, irrespective of where death occurred. An increase in deaths outside of Chicago resulted in little improvement in the resident rate for 1958.

‡Provisional

TABLE 2.—Chicago Mass X-Ray Survey. Number of X-Rays Developed and Read by Municipal Tuberculosis Sanitarium

1950	380,000
1951	402,000
1952	470,000
1953	473,000
1954	600,000
1955	750,000
1956	873,000
1957	836,176
1958	738,895
1959	800,607

The number of x-rays developed and read by the Municipal Tuberculosis Sanitarium has increased from 380,000 to 800,000 over the ten-year period. These x-rays are taken by the units of the Tuberculosis Institute of Chicago and Cook County and the Municipal Tuberculosis Sanitarium. The high point was reached in 1956, with 873,000. After a review of the situation by members of the various interested organizations, it was decided to make the program more selective and not look for increased numbers.

TABLE 3.—Number of Patient Visits at Municipal Tuberculosis Sanitarium Clinics

1950	136,384
1951	147,644
1952	161,600
1953	185,000
1954	236,000
1955	276,000
1956	293,000
1957	314,328
1958	310,832
1959	307,226

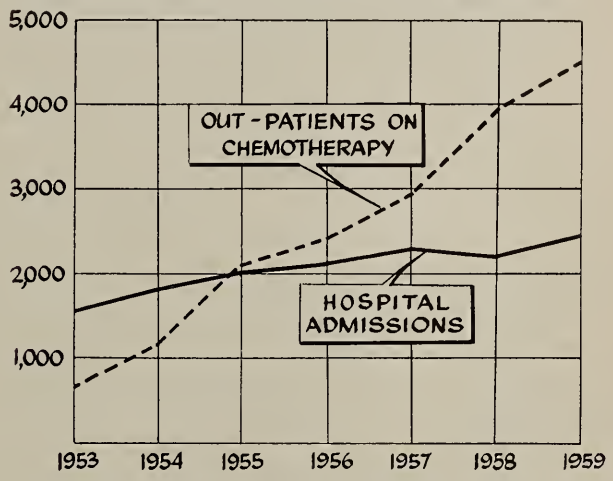
The increasing number of patient visits annually is due largely to the increasing chemotherapy program carried out in the clinics.

TABLE 4.—Number of Patients Receiving Chemotherapy in Municipal Tuberculosis Sanitarium Hospitals and Clinics at Year End, 1959

Year	Sanitarium	Clinics
1955	1289	2091
1956	1211	2416
1957	1295	2937
1958	1135	3942*
1959	1235	4501*

*Includes about 600 infants.

TABLE 5.—Municipal Tuberculosis Sanitarium Admissions and Out-Patients on Chemotherapy



1953 was the first year of out-patient chemotherapy in all Municipal Tuberculosis Sanitarium Clinics. Hospital admissions have increased by 900, due to earlier discharge to out-patient clinic care. Chemotherapy for out-patients has continuously increased, due, in part, to the addition of a prophylactic program for children, instituted in 1958, and the availability of this service to out-patients of other tuberculosis facilities (Veterans Administration hospitals, Chicago State Tuberculosis Sanitarium, Cook County Hospital, State Mental institutions, etc.).

The female prostate

Although hardly recognised in this country, bladder-neck obstruction in women is a very real condition which is not so very uncommon. In a previous communication I described eleven cases (1952). This paper is based upon thirty-three cases encountered since 1948. Not infrequently the wife of one of my prostatic patients has said to me, "I am sure I have the same trouble myself; I have just the same symptoms." Sometimes this diagnosis has been correct. In one family I have removed a grandfather's prostate, his son's, and his daughter-in-law's, all with equally good results! *Thomas Moore, M.D. The Female Prostate. The Lancet. June 18, 1960.*

Intussusception

Cook County Hospital

Moderator:
Robert J. Baker, M.D.
Associate Director, Department of Surgical Education, Cook County Hospital
Discussants:
Paul F. Fox, M.D.
Associate Attending Surgeon, Children's Memorial Hospital and Attending Surgeon, St. Anne's Hospital; Clinical Associate Professor of Surgery, the Stritch School of Medicine of Loyola University.
John B. Condon, M.D.
Attending Surgeon, Cook County Hospital; Clinical Associate Professor of Surgery, Stritch School of Medicine of Loyola University

Dr. Robert J. Baker: The conference this morning will deal with a subject of vital interest to all physicians who treat children's diseases, medical and surgical. As has been frequently emphasized, intussusception is one of the most dramatic and important surgical emergencies in infancy and early childhood. Successful management requires experience and sound judgment.

This subject has been extensively written about, in part because of the dramatic phenomenon of a previously well baby who suddenly becomes acutely, if not desperately, ill. The death rate has dropped impressively in the last few years, primarily because of earlier recognition and prompt treatment, such as will be outlined in this conference.

Our two discussants have been very interested in this subject, have taught it and written about it. Our guest speaker is Dr. Paul F. Fox, who was an associate attending surgeon here for several years, and whom we prefer to think of as a good friend, rather than a guest. Dr. John B. Condon, our second speaker, is an attending surgeon on the Pediatric Surgical Service.

Case 1.

Dr. Robert Eberle, surgical resident: The patient was a 19 month old, previously well Negro female, admitted to the Pediatric Surgical Service of Cook County Hospital with a history of vomiting and periumbilical abdominal pain for approximately 21 hours. She had vomited about every half hour, and most of the emesis had been of green, thin fluid. As described by the mother, the abdominal pain was "colicky" and occurred every 15 minutes or so.

Physical examination showed a well nourished child in marked distress. A mass was easily palpable in the right upper quadrant and across to the epigastrium. The right lower quadrant had an "empty" feeling. Rectal examination showed "currant jelly" stool on the examining glove; no masses were detected.

The child was taken to the x-ray department, and a barium enema, performed cautiously, demonstrated an obstruction to the flow at the hepatic flexure. Several loops of distended small bowel also were seen.



Figure 1. Barium enema showing filling defect in the hepatic flexure; the arrow points to the "claw" deformity characteristic of intussusception.

Dr. Baker: The first x-ray we will show you is the barium enema (fig. 1.)

Dr. Leon Love: What is seen is rectum at the bottom of the film, and the transverse colon is dilated. There is a radiolucent filling defect on the right side which represents intussusception of the cecum and terminal ileum. There are multiple dilated loops of small bowel. The colon has the classical appearance of radiolucency and the coil spring, or "claw" appearance, of an intussusception.

Dr. Baker: Can you ascertain the degree of obstruction?

Dr. Love: I cannot estimate that from this x-ray.

Dr. Baker: This child was a previously healthy female child, admitted to the hospital with a classical history, physical findings and x-ray evidence of intussusception. The radiologist who did the x-rays attempted with gentle pressure to reduce the intussusception, but no progress was made; so the patient was taken to surgery for open reduction. An ileoileocolic intussusception was found and reduced. Figure 2 shows that the intussusception has been partially reduced, and you can see the ileoileal component of this lesion and the discoloration which gave the surgeon real concern. The bluish-gray color indicated that gangrene could be present in the intussuscepted ileum, but on further reduction, it was seen that both components of the lesion were viable.

As noted in the description of the physical findings, Dance's sign was elicited, i.e., an "empty" feeling in the right lower quadrant resulting from the dislocation of the cecum up into the distal colon.

We will ask Dr. Condon to discuss the general problem of intussusception and present his ideas on diagnosis and treatment.

Dr John B. Condon: Since we have reviewed the cases of intussusception at this hospital on two occasions, covering the period of the past 31 years, I thought you might be interested in the figures. The first series covered a period of 21 years, 1925 to 1945, and this was broken down into three 7-year periods. The reason for doing this was to show the progressive lowering of mortality. One is impressed that in the earlier years the mortality in these cases was more than 50 per cent, which was in keeping with the results that were being obtained elsewhere. In the next seven years (1933-1939) the mortality rate



Figure 2. Ileoileal component exposed and held up at the tip of the surgeon's finger with proximal collapsed bowel to the right, held in the surgeon's right hand. The bowel under the operator's thumb is the cecum, from which the ileoileal mass had just been delivered.

was reduced to less than 20 per cent. The tremendous increase in the number of cases seen in the period from 1939 to 1945 is noteworthy. I have no explanation for this other than the fact that our diagnostic acumen must have improved; happily, the mortality rate dropped to 10 per cent. Subsequently we were anxious to see if the frequency of cases was holding up, so we decided to review the years 1946 to 1955. We had 58 cases with no deaths. Actually, two other cases were admitted in a moribund state and died within six hours, but, in all justice to the surgical department, it was felt that these could be excluded. We had six cases of irreducible intussusception at the time of operation. A total of 157 cases were seen in the 30 years under discussion, and the overall mortality rate has been less than 10 per cent, 8.2 per cent to be exact.

The greatest incidence of intussusception was between 3 and 9 months of age, and is consistent with other reports. A breakdown as to sex and race shows a predominance in the Negro child, but this is probably due to the nature of our hospital census as compared to a private hospital. We do not feel there is any racial susceptibility in this condition.

As to the symptoms and findings contributing to the diagnosis, abdominal pain has been the most prominent feature; it occurred in 91.4 per cent of our cases. Bloody stool, which has been referred to as the currant jelly-like stool, has not impressed us as a universal finding; gross blood, or positive chemical tests for blood, was noted in 86 per cent of the series of 58 cases from 1946 to 1955.

Vomiting occurred in 80 per cent; a palpable abdominal mass, in more than three fourths of the cases. Actually, the mass should be palpable in most instances, but in distended children with some degree of rigidity, and especially when the mass is under the costal margin, difficulty may be encountered in palpating it.

We have been impressed with the number of infants admitted in shock, or in a preshock state often described merely as listlessness. We have interpreted this as shock or preshock, and we think it has been underemphasized. Signs of obstruction were present in a much smaller proportion in the later series, perhaps because more of these children were seen earlier. A palpable rectal mass was present in seven instances. This does not mean palpation of the mass but rather of the head of the intussusceptum.

The diagnosis in this series of cases has been missed surprisingly infrequently. The pitfalls in cases of missed diagnosis were (1) a child not in the typical age group; (2) no coexisting or preexisting illness; (3) a chronic condition. In one or two instances we have seen what we term chronic intussusception. This could have been an intussusception which spontaneously reduced and then recurred, we do not know, but when the patient came to surgery very late there were minimal changes. In several instances acute appendicitis was the working diagnosis because of pain in the right lower quadrant and a vaguely defined mass.

As to treatment of these cases, manual reduction with surgery was done in 35; appendectomy was included in 3 additional cases. In another there was repair of split serosa in or on the ileum, and 1 of the cecum. One of the recurrences of intussusception followed an appendectomy, and the invaginated appendiceal stump was in the intussusception. In no instance was ileal resection with any portion of the cecum or colon indicated or necessary. Nonsurgical treatment was accomplished by barium enema in 10 cases. We have felt that this is not the treatment of choice. In 1 instance the intussusception spontaneously subsided without surgery.

Over the years and as our experience increases, we have continued to teach that in the usual case of intussusception surgical treatment should be advised and carried out. Manual reduction is usually possible. We discourage the practice of exerting traction on the intussuscepted bowel to pull it out of the intussuscipiens. It is an easy way to damage a bowel that might otherwise be viable. The proper method of reduction is to push, or milk back, the intussusceptum from the most distal point toward the site of invagination. The key to successful reduction is gentleness in handling bowel that is frequently edematous and friable.

When it is not reducible and when loss of viability of the bowel is present, resection is indicated. In the earlier cases, exteriorization procedures were attempted. Subsequently the pendulum has swung to primary resection and anastomosis. As for the criteria for using barium enema, there are some people who advocate routine initial attempts at barium enema reduction.

We are more conservative and reluctant to advocate it. Attempted barium enema reduction should be limited to specific cases which fill certain criteria: (1) a history of 24 hours' duration or less; (2) relatively little or no temperature elevation, leukocytosis, or signs of toxicity; (3) no signs of shock nor obstruction; (4) the subacute or chronic recurring type. When reduction by barium enema is attempted, I feel strongly that the radiologist and the pediatrician should not procrastinate or gamble with the uncertainty of reduction. If the above criteria are present, physicians are justified in being more aggressive than they might be in the more critically ill infant. We should like to emphasize that the pressure of the column of barium should never exceed 36 inches; the enema should be elevated manually not above 36 inches, and aggressive or traumatic abdominal palpation as an accompaniment is contraindicated.

Dr. Baker: Dr. Fox, our most interesting discussions at these conferences center around disagreement. Could we stimulate you a little in this direction?

Dr. Paul F. Fox: No, I don't think so. I agree for the most part with what Dr. Condon has said. I was very much impressed with his figures showing reduction in mortality over a period of years.

One thing that would fit into his discussion, one he would have enlarged on if he had had more time, was this shock or preshock condition where the child is listless and perspiring freely and often very pale. It is a common observation, and yet it is well known that these children do not lose much blood per rectum. It has been emphasized that they lose a substantial amount of fluid into the intussuscepted segment and proximal bowel. It does not take much fluid and salt loss to upset a baby's fluid and electrolyte equilibrium. If the child has had the intussusception for several hours and is pale, it is wise to give blood and plasma, even though there is not much actual blood loss to the exterior.

I think that I agree with Dr. Condon with regard to barium enema versus surgical reduction. Surgical reduction is the best procedure in my opinion, and any associated existing pathology, although admittedly rare, can be taken care of at the time of operation. I have used barium enema reduction in one patient who had three recurrences following surgical reduction. In most series the recurrence rate does not constitute more than 2 per cent of the cases, but that patient apparently had a propensity for intussusception and it recurred. One wonders, in such a case, whether the old method of suturing the ileum along the medial aspect of the cecum might not be indicated. I have operated on one adult who had been operated on during infancy for intussusception. The surgeon tacked the ileum along the cecum for a distance of 5 cm., and as far as I could tell from the history and abdominal findings, the result was excellent.

Dr. Baker: We appreciate the comments of the discussants, and now will proceed to the second case, which presents a more difficult therapeutic dilemma.

Case 2

Dr. William Reed, surgical resident: This two month old Negro female was admitted in a moribund state to the Cook County Children's Hospital with a one week history of six to seven watery yellow stools each day. Anorexia was noted but vomiting was denied. Prior to the onset of these complaints the child's health and development had been normal.

Physical examination revealed an emaciated, severely dehydrated infant in shock, with respiratory distress, cyanosis, and cold extremities. Clear lung fields, a respiratory rate of 60 per minute and marked retractions were seen. The heart rate was 200 per minute; heart tones were faint and no murmurs were audible. The abdomen was scaphoid with liver and spleen readily palpable, but no masses or other abnormalities were noted.

Emergency diarrhea management was instituted, including cut-down (no bleeding noted), sodium lactate, Chloromycetin®, and plasma. The child's course was one of slow improvement complicated by bronchopneumonia. A cardiac consultant on the second hospital day diagnosed myocarditis and heart failure, and digitoxin was started. On the following day the child was distended and experienced a convulsion. Green emesis occurred, and bowel sounds were described as high pitched. A vaguely outlined mass was palpable in the right lower quadrant, and the rectal temperature was 100°F. Bright pink, glairy, mucoid material was passed per rectum. Scout films and diagnostic barium enema were interpreted as compatible with intussusception.

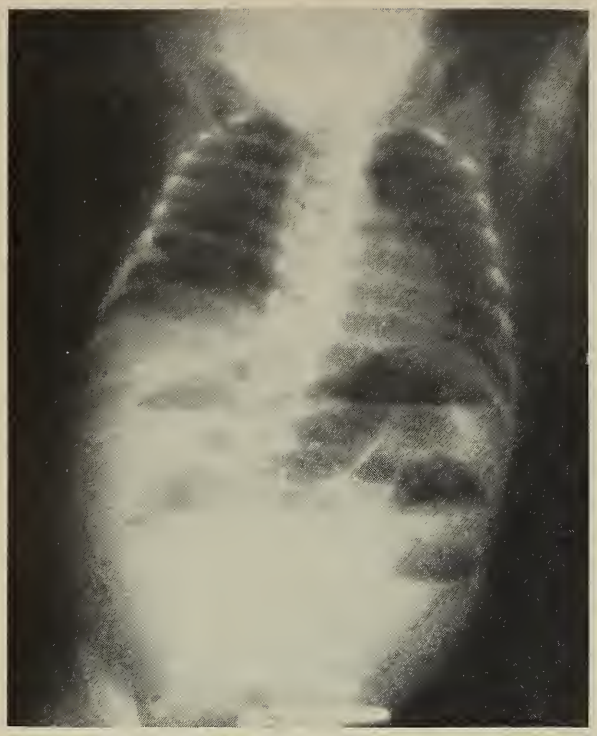


Figure 3. Plain upright film showing multiple air-fluid levels in the upper and mid-abdomen.

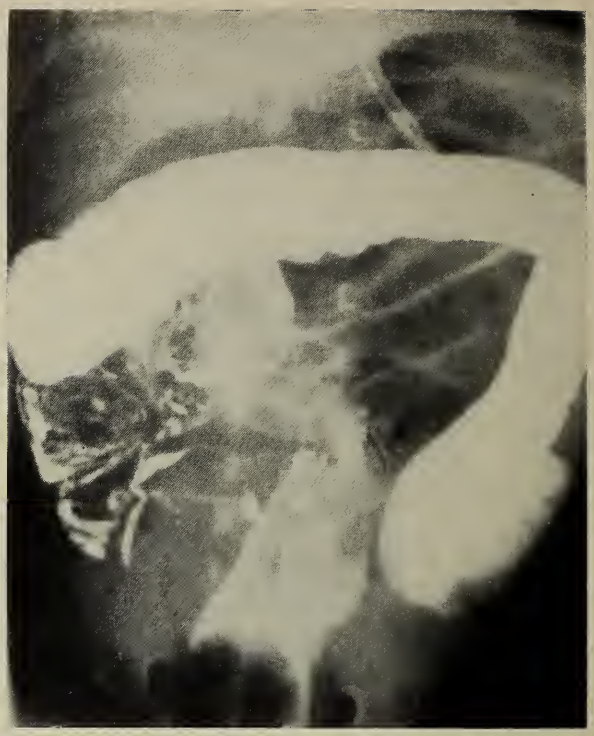


Figure 4. Barium enema showing filling defect in the ascending colon, suggestive of intussusception.

Dr. Leon Love: The first film (fig. 3) taken on February 9 is of considerable interest because we see multiple dilated fluid levels. These fluid levels are long and straight, and it is noteworthy that there are not two heights of air-fluid interfaee in the same loop. This indieates ehronicity and probable small bowel obstruetion. This pieture eould not be obtained if the duration of the eondition were under 24 hours; so it should be assumed that the obstruetion is at least that old. This film shows only small bowel involvement and would most likely represent intussuseeption in the light of the patient's age.

There is an interval of two hours between the first film and this seeond one, a barium enema, whieh shows free flow of barium until it reaehes the right side of the colon where there is a huge filling defect (fig. 4). A coil spring appearanee is not apparent. The appendix is outlined. This is eharaeteristic of intussusception of ileocecal type. The dilated loops of small bowel are seen proximal to the obstructing site.

In this case, where the diagnosis was uneovered on the first film and it was established that the eondition was at least 24 hours old, the patient is not a suitable eandidate for barium reduction of the intussuseeption.

Dr. Baker: Dr. Greengard, we are delighted to have you here. This ehild was admitted with a bizarre, atypieal picture for this disease but not unusual for infeetious diarrhea. Would you give us your opinion?

Dr. Joseph Greengard, direetor of medieal edueation in pediatrics: I would like first to comment on the first ease presented, with my remarks direeted primarily to the pediatrie interns and residents. That was a child who presented a cleareut picture of intussusception. In spite of that, whoever was in charge sent the ehild over for barium enema, and I disagree vehemently with that proeedure. There are situations in whieh x-ray is extremely valuable and enlightening and perhaps benefieial, but there are other situations, in pediatric practice, and partieularly in emergency surgieal problems in ehildren, where you should not waste time on an x-ray procedure. I have seen this happen repeatedly in my private work. There is too much tendency to disregard clinieal findings and the use of a little gray matter, and resort to a laboratory aid instead to make a diagnosis. This ease was a beautiful example of just this thing, and I welcome the chance to comment on it. The pediatrieian should have called the surgeon

immediately so that this child could have had definitive surgery without delay. The situation was 24 hours old already on admission, and there is absolutely no sense in wasting two or three hours in the x-ray department.

So far as reduction by barium enema is concerned, from a pediatrician's standpoint, I would say that reduction is a surgical problem; and I would disagree with any pediatrician or radiologist who had the temerity to reduce an intussusception by barium enema. I feel very strongly about this. There may be a place for reduction by hydrostatic pressure, but that must be decided by the surgeon. If you were out in practice as a pediatrician and you encountered intussusception and made the diagnosis, then your obligation is to treat it as a surgical emergency. Call in the best surgeon you know; if he wants to utilize hydrostatic pressure, that is his decision. I think, however, it would be best to do it in very close proximity to an operating room and have that operating room fully prepared.

Dr. Freeark and I were involved in the second case. It presented a very difficult problem because we were dealing with a child who was extremely ill, who had had diarrhea for a week, was moribund, was in heart failure, and had pneumonia. Whatever we did, we had three strikes against us from the first. Here we did temporize a bit that first day. We talked a lot about hydrostatic reduction, and we did a barium enema; but as we talked we felt that if we did manual reduction, we would do it with the operating room conveniently ready so that if reduction was not accomplished, we could proceed with surgery. Diarrhea, as you know, is one of the important etiologic factors in producing intussusception. In a situation like this, one would have reason to feel that not only would there be an ileocolic intussusception but also an ileoileal intussusception, and probably multiple ones. So this child certainly should have been explored, but we both felt that the chances for success were slim indeed.

Dr. Robert J. Freeark, director of surgical education: The resuscitation efforts put forth in this child's behalf were magnificent. The child was considered hopeless on arrival at the hospital, but he made a remarkable recovery by virtue of the vigorous efforts of the pediatric staff. As Dr. Greengard said, we were interested in a barium enema from a therapeutic standpoint; this was done in x-ray adjacent to the operating room. Reduction was not successful by that method, and on exploration, there was a question of viability of the bowel; it looked viable but we were not too certain. This is one of the dilemmas that must be faced in surgery, and on such a day you would give anything for about 30 years' experience of just looking at questionably viable bowel. This child was so ill that we wished to avoid resection if it was at all possible. We felt also that we had to prevent prolonged operative delay, and observation of the behavior of the affected loop, peristalsis and bleeding would have taken too long. It was my own impression that the bowel was viable and with that decision it was returned to the abdomen. Had the child been in better condition we would have been inclined to resect that bowel. I cannot remember a case which required a more difficult decision. At least three feet of bowel was intussuscepted. The reduction, once it was started by the technic of milking the head of the intussusceptum, proceeded quite easily and, in my opinion, was further evidence of viability; there was some peristalsis following reduction. The color was not too good, however, and certainly it was a borderline situation throughout.

Dr. Fox: It is often difficult to decide whether a loop of bowel is viable, and there is no sure method of determining viability, so it must remain a matter of personal judgment. However, it is better to resect when in doubt. From the description of the surgery, it is evident that the bowel showed peristalsis, and I would be inclined not to resect in such a poor risk patient. It is possible that after the operation something happened to the blood supply that caused the bowel to lose its viability and result in the death of the patient, which was most unfortunate. With any disorder of a serious nature there will be some mortality, and I certainly could not criticize the management of this patient from the evidence presented.

Dr. Baker: I did not mention this, but in the first case we removed the appendix. What is your feeling about that in simple reduction of an intussusception?

Dr. Fox: I don't know whether Dr. Greengard will agree, but we think that the patient with an easily reducible intussusception is a good risk patient, and incidental appendectomy will

not jeopardize the chances for recovery. A review of our records for 10 years showed that none of these cases terminated fatally, nor did we find any complications from the incidental appendectomy.

Dr. Baker: What type of incision do you recommend for intussusception?

Dr. Fox: A McBurney incision is our preference in an intussusception of relatively short duration in a good risk patient. If you anticipate having to do a resection, however, a right paramedian lower abdominal incision is preferable. For most instances of intussusception, the McBurney approach is very satisfactory. Even when we have had the intussusceptum protruding through the rectum, they seem to slip back without trouble. (We have seen that in two instances, and we have seen several instances where the intussusceptum was palpable.) As a rule, you can reach through a McBurney incision and reduce the intussusception readily and quickly. If you are going to have difficulty in reduction, you will have it on the right side, and a McBurney incision gives adequate exposure.

Dr. Baker: A McBurney incision was used in this case and the operation was performed under local anesthesia. The patient did fairly well postoperatively for a few days, but then she became distended. The blood urea nitrogen rose, sodium was 168 mEq./L., chloride was elevated, and potassium was high. The pediatric staff did a herculean job of keeping her alive for six days, but she terminated with severe icterus and sepsis.

Figure 5 is a postmortem photograph and shows the abdominal viscera in situ; when the abdomen was opened, 250 cc. of free fecal material was present in the peritoneal cavity. There was a large right subhepatic abscess and an area of necrosis proximal to the cecum, granulation of the distal ileum, and perforations in the ileum which leaked fecal material; the pointer in the picture demonstrates the perforation.

In retrospect, this was a patient in whom the decision not to resect is one that we view with regret. One's vision in hindsight is always good, whereas, when facing the problem it is not always as clear. This was a most difficult decision to make, and only the surgeon could make it. I should like to point out that the perforation was a very small one, and on the mesenteric side of the bowel.



Figure 5. Autopsy specimen showing necrosis of the ileum at the mesenteric border (pointer). The discoloration extends into the mesentery.

Dr. Condon: I want to make some additional comments. As long as any controversy is suggested, it is only honest that I comment.

In regard to doing an incidental appendectomy in Case 1 at the time of the reduction, I would be inclined not to do it, mainly because in the series which I presented there were two cases of recurrent intussusception, both of which we felt were due to invaginated appendiceal stump. If you do an incidental appendectomy, be careful about how much you invaginate the stump. On the other hand, where there is any question of compromise to the circulation of the appendix, then by all means I would be in favor of doing an appendectomy at the time of reduction.

We are convinced that in 90 per cent of cases of intussusception the diagnosis is so obvious that there is no question. Intussusception is presumably the most common cause of bowel obstruction in the infant during the first 12 months of life.

As to the short-circuiting procedure in these cases, I would be fearful of it, especially in Case 2, because of partially reduced nonviable bowel. The open resection or the Mikulicz type of operation seems easiest and quickest, but with infants who are sick, and certainly toxic, you will have a small bowel loop outside the abdomen, and the electrolyte balance may pose a formidable problem. Massive primary resection is most desirable, but it may be to much surgery. Dr. Keeley has described a T-anastomosis in which the proximal end of the resected colon is exteriorized, the ileum is brought up, devascularized, crushed at the end, put into the colon, and

anchored with a one-layer suture sewing the small bowel serosa to the seromuscular layer of the colon. This offers the simplicity of the Mikulicz type of exteriorization, and leaves a vented anastomosis. I would favor such a procedure in a similar situation.

Dr. Freeark: I agree entirely. Viability in terms of the bowel is a total thing. The major part of the bowel wall may well appear viable, it may have peristalsis, and everything else may seem fine; but all you need is one bad site to negate all your efforts. When in doubt one should err on the side of surgical removal of this area, but these pinpoint areas of questionable viability I think are the most difficult of all to detect. Peristalsis may go through that loop of bowel, but it is a 0.5 cm. site of necrosis that leads to the fatality.

Dr. Baker: I wish to thank all the discussants for their valuable contributions to our knowledge of intussusception.

Points to remember — a summary

1. Intussusception is the telescoping of a portion of small or large bowel into a more distal portion of the bowel. The proximal segment is called the *intussusceptum*, and it almost invariably invaginates into the distal segment, or *intussuscepiens*.

2. In children the vast majority of cases show no apparent reason for the intussusception. In adults, on the other hand, there is usually a mechanical abnormality present, as, e.g., polyp, tumor.

Almost 90 percent of these cases in large series in children are ileocolic in location and, more important, start near the ileocecal valve. Some may be compound, in which ileum enters ileum; then the entire mass enters colon. These are called "ileo-ileocolic."

3. The child who develops classical intussusception falls into the following pattern:

- **a. Between three months and one year of age.**
- **b. Previously healthy, well-nourished baby.**
- **c. Sudden onset of severe paroxysms of abdominal pain (child becomes pale, draws legs up, cries).**
- **d. Vomiting may be frequent and severe.**
- **e. Passage of bloody ("currant-jelly") stools, usually not until twelve hours or more have elapsed.**

4. Physical examination will elicit abdominal tenderness in only 40 percent of patients; an abdominal mass can be felt in *85 percent* of cases. If the intussusception should involve small intestine only, the mass is frequently too mobile to be felt. Dance's sign is a feeling of "emptiness" in the right lower quadrant with dislocation of the cecum up into the colon.

5. Rectal examination usually will yield blood on the examining finger, and the tip of the intussusception may occasionally be felt. It is extremely important, if the mass is hard to feel abdominally, to do a rectoabdominal examination in an attempt to ballotte the mass between the rectal finger and the examining hand on the abdomen.

6. One of the most common diagnostic errors in this type of patient lies in making the diagnosis of dysentery, based upon the fever, vomiting, bloody stools, and abdominal pain. A flat film showing distended small bowel without much gas in the colon is an indication for barium enema, which will usually reveal the diagnosis.

7. The barium enema is characterized by the following:

- **a. Obstruction to the barium column.**
- **b. "Cupping" defect in the head of the barium as it meets the intussusceptum.**
- **c. A thin casing of barium surrounding the intussusceptum and inside the intussusceptiens.**
- **d. A cylindrical shell of barium, around the intussusceptum, remaining on the postevacuation film.**
- **e. Gaseous distention of the ileum just proximal to the pathology.**

8. Reduction of the intussusception falls into two categories, non-operative and operative. The non-operative method consists of reduction by increasing intraluminal pressure with fluid or air (currently barium is being used) *gently*, so as to force the intussusceptum backwards. It is extremely important, with this method, *never* to manipulate the mass through the abdominal wall. Operative reduction should be as simple as possible, with resection only if the intussusception is nonreducible, or if the bowel is nonviable when reduced.

9. As in other surgical emergencies, preoperative preparation is mandatory, and a few hours judiciously spent in the administration of blood, fluids, plasma, gastric suction, oxygen, and antibiotics may spell the difference between survival and death.

10. Regardless of the method of treatment, the most effective way to reduce the mortality of intussusception is to shorten the period between the onset of symptoms and the initiation of treatment. The golden period for successful therapy is the first 24 hours.

REFERENCES

1. Condon, J. B., and Oberhelman, H. A.: Further Studies on Intussusception in Infants and Children, A.M.A. Arch. Surg. 73:349, 1956.
2. Fox, P. F.: Intussusception, Surgical Treatment, Surg. Clin. N. America: 1501, Dec., 1956.
3. Gross, R. F.: The Surgery of Infancy and Childhood. Philadelphia, W. B. Saunders Co., 1953.
4. Ravitch, M. M.: Intussusception in Infants and Children. Springfield, Ill., Charles C Thomas Co., 1959.

A coronary study

Included in our normal group were 30 cases of imbeciles and morons, and we have come to the conclusion that in order to keep the coronary vessels in a healthy condition, one should perhaps be more idiotic and moronic. *A. A. Leonidoff, M.D. Silent Myocardial Infarction. Dis. Chest. May 1960.*

Dietary Carbohydrate And Blood Lipid Levels

JOHN W. GOFMAN, M.D.* *Berkeley, Calif.*

THE PAST FIVE years have witnessed an enormous growth of interest in the prospect that dietary factors may be manipulated in the effort to control arteriosclerosis and its clinical sequelae. So rapid has been this growth that the basic rationale underlying this approach may be forgotten. The net effect can be either an invalid test of the real possibilities of dietary control or even real harm to certain patients whose diet is being manipulated.

Evidence has accumulated from numerous investigations throughout the world that (1) groups of persons with a clinical sequel of arteriosclerosis, such as coronary heart disease, show higher levels of certain blood lipids than do matched groups of persons without manifest disease; and (2) that higher levels of blood lipids precede evidence of disease. These central facts, overtly or tacitly, underlie the current popularity of dietary approaches to control of arteriosclerosis. The obvious thought is that it might be worthwhile to lower the blood level of a constituent, the elevation of which is statistically shown to precede disease. In itself this thought is eminently worth evaluation. However, it becomes critical to know precisely *which* blood lipids to reduce. Unfortunately, in this sphere confusion reigns in the medical world.

The reasons underlying the confusion deserve appreaciation by every physician interested in this problem. Early investigators who established the principle that high blood lipids precede clinical evidence of coronary heart disease measured blood lipids in a variety of ways: (1) the level of certain classes of blood lipoproteins, (2) the level of triglyceride, and (3) the level of cholesterol. Controversies arose concerning which measurement was the best, when the criteria for "best" involved such features as simplicity, cost, and equipment. Such controversies usually would be of trivial consequence, but the measurement problem is crucial to the entire issue of dietary control of blood lipids. This is true because the measurements listed above are *not* all reflections of the same entity.

Careful chemical studies have shown that the blood cholesterol is closely related to one major class of lipoproteins, the $S_f°0$-20 lipoproteins, which have a high cholesterol content. The blood triglyceride is closely related to that of another great class of lipoproteins, the $S_f°20$-400's which have a high triglyceride content .

Dietary studies show clearly that a high intake of animal or saturated fat, in general, tends to elevate $S_f°0$-20 lipoproteins, hence to elevate the blood cholesterol level. However, the effect of the type of dietary fat upon the triglyceride-bearing $S_i°20$-400 lipoproteins is negligible. On the other hand, high carbohydrate intake tends to elevate the $S_f°20$-400 lipoproteins, and hence the blood triglyceride level. Carbohydrates have no influence on the $S_f°0$-20 lipoproteins nor the blood cholesterol level. The mechanism by which dietary carbohydrate influences the blood level of the triglyceride-bearing $S_f°20$-400 lipoproteins is unknown. These triglyceride-bearing lipoproteins are enormously elevated in hyperglycemic diabetic acidosis and in hypoglycemic glycogen storage disease. Thus blood glucose level seems not to be the major issue; rather the problem

*Professor of medical physics, Donner Laboratory, University of California, Berkeley.

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would appear to lie in the status of the carbohydrate metabolism of the individual.

Several investigators have shown that a low fat-high carbohydrate diet produces opposite trends in the blood cholesterol and the blood triglyceride levels. The cholesterol level falls because the low fat diet depresses the level of the cholesterol-rich $S_f°0$-20 lipoproteins. The triglyceride level rises because the high carbohydrate intake elevates the level of the triglyceride-rich $S_f°20$-400 lipoproteins. Both the triglyceride-bearing and the cholesterol-bearing lipoproteins have been associated with the development of coronary disease. It therefore behooves the physician utilizing the dietary approach to understand the likelihood that a focus upon fat intake without an appreciation of the effect of carbohydrate intake will not lower all the blood lipids associated with the development of coronary heart disease.

Rats, chickens, mice—and man

One of the most important medical problems being studied today is seriously hampered by an unusually large number of animal species differences. Among the key points of attack in the investigation of the causes of coronary heart disease is the lack of correlation between findings in man and those in a host of experimental animals, a circumstance which has become the rule rather than the exception. The morphologic features of the atheromatous plaques that are produced by extreme elevation of blood cholesterol in the experimental animal do not reflect in all details the condition found in man. The development of a thrombus at the site of the atheroma has not been accurately reproduced in the laboratory animal. The intricate biochemical steps in the blood-clotting and plasmin systems in man differ in important ways from those in other animals. The pattern of lipoproteins, particularly the ratio of the so-called alpha and beta fractions and the influence of dietary fat on these fractions, are not the same for man and his laboratory counterpart. The effect of fat ingestion and the influence of the degree and type of unsaturation of the fat on the level of blood cholesterol frequently does not follow the same pattern when one moves from man to various other animal species.

Such examples as these emphasize some of the difficulties in transposing laboratory findings to the human subject. If we seek an understanding of a disease process or a treatment of that disease, the final answer can come only from the clinical patient. This must not be interpreted as a justification to abolish or reduce animal experimentation. Rather, these examples of lack of correlation should emphasize the need for the investigator to establish firmly the fundamental cellular or subcellular biochemical metabolic phenomena that are involved. Then, as he utilizes the intact animal to seek out nonmetabolic possibilities that might cause species differences, he can extend his studies to a wide assortment of animals in the hope of finding parallelisms that will be helpful. However, he should always tread cautiously in interpreting the results he obtains in the laboratory. *Richard H. Barnes, Ph. D. The Span from Rat to Man. New York State J. Med. Aug. 1, 1959.*

Appetite suppressor for patients on rauwolfia

Forty-one overweight hypertensive patients, ranging in age from 28 to 68 years, were placed on some form of rauwolfia for blood pressure reduction as required, and a low-salt, low-calorie diet. Adjunctively, levo-1-phenyl-2-aminopropane alginate was employed to control the urge to eat usually resulting from rauwolfia medication. The drug was administered t.i.d., before meals, in doses of 1 tablet (5 mg.) and, in a number of cases, also at 8 p.m. In a few patients, two tablets three time daily may be required to get the best results.

Observations during this study indicate that this appetite suppressant can safely be used in hypertensives without CNS disturbance, and it can be successfully used to combat the night-time eating habit without causing insomnia. It also accomplished weight reduction in 40 of the 41 cases under study in spite of rauwolfia therapy which ordinarily tends to promote weight gain. *Harold S. Feldman, M.D. and Raymond J. Gadek, M.D. Prevention of Therapeutically Induced Weight Gains in Hypertensive Patients. Clin. Med. Jan. 1960.*

The Present Status of Polio Vaccines*

MODERATOR:
Herbert Ratner, M.D., Director of Public Health, Oak Park, and Associate Clinical Professor of Preventive Medicine and Public Health, Stritch School of Medicine, Chicago.

PANELISTS:
Herald R. Cox, Sc.D., Pearl River, N.Y.; Bernard G. Greenberg, Ph.D., Chapel Hill, N.C.; Herman Kleinman, M.D., Minneapolis; Paul Meier, Ph.D., Chicago.

PART I

DR. HERBERT RATNER: In this panel we are first going to discuss the Salk vaccine, later the live virus vaccine. None of us have any commitments or allegiances except to the truth. Dr. Cox, of course, is from a pharmaceutical house, but he is not here to sell you his vaccine. He happens to be one of the world's leading authorities on live virus vaccines, as well as killed vaccines. His reputation for integrity is exceptional and unchallenged. He has devoted 14 years to the development of the live poliovirus vaccine specifically. He is here to share his knowledge with you. You will have full freedom to question and to dispute. Dr. Cox is director of virus research at Lederle, and is at present, president elect of the Society of American Bacteriologists.

Dr. Kleinman is an epidemiologist from the Minnesota Department of Health. He is intimately connected with that department's pioneering field studies on the Cox live poliovirus vaccine. Yesterday, he landed from Russia, where he was an official delegate of the USPHS at a conference on poliovirus vaccines. He was coauthor in 1957 with Dr. Leonard Schuman of a paper entitled, *The Efficacy of Poliomyelitis Vaccine with Special Reference to Its Use in Minnesota 1955-1956,* wherein they concluded that "analysis has revealed (that) the use of two doses of Salk poliomyelitis vaccine . . . . . (was) 83% protective against paralytic poliomyelitis."[1]

Professor Meier is a biostatistician from the University of Chicago. In the field of polio, he is best known for his analysis "Safety Testing of Poliomyelitis Vaccine" (Science, May 31, 1957), which suggested that a searching study of the entire Salk vaccine program by an appropriate body be conducted. Despite the attempt of the editors to initiate a debate on the crucial issue of safety testing, proponents of the Salk vaccine remained silent.

Professor Greenberg is head of the department of biostatistics of the University of North Carolina, School of Public Health and former chairman of the Committee on Evaluation and Standards of the American Public Health Association. In the past he has presented several papers on methodologic problems in the determination of the efficacy of the Salk vaccine.[2]

The reason for this panel on the present status of polio vaccines is best expressed by a quote from Dr. Alexander Langmuir. He is in charge of polio surveillance for the USPHS, and has been an ardent proponent of the Salk vaccine even prior to the Francis report of 1955. In a symposium on polio in New Jersey last month he stated that a current resurgence of the disease, particularly the paralytic form, provides "cause for immediate concern" and that the upward polio trend in the United States during the past two years "has been a sobering experience for overenthusiastic health officers and epidemiologists alike."[3]

In the fall of 1955 Dr. Langmuir had predicted that by 1957 there would be less than 100 cases of paralytic polio in the United States.[4] As you know, four years and 300 million doses of Salk vaccine later, we had in 1959 approximately 6,000 cases of paralytic polio, 1,000 of which were in persons who had received three, four, and more shots of the Salk vaccine. So you see, expectancy of the Salk vaccine has not lived

This panel discussion was edited from a transcript. Opinions presented are those of the panel members and do not necessarily represent those of the Society.

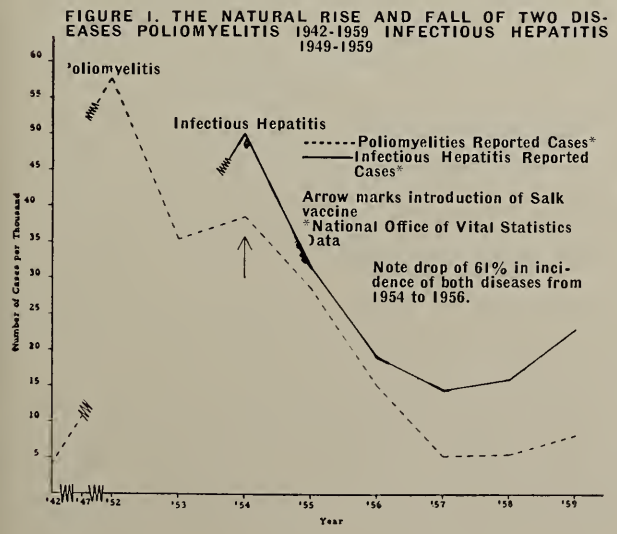
**Presented before the Section on Preventive Medicine and Public Health at the 120th annual meeting of the ISMS in Chicago, May 26, 1960.*

TABLE 1.—Paralytic Polio Cases in the U.S. in 1957, 1958, 1959, Including Paralytic Polio Cases in Salk Vaccines.

	Total	Increase over 1957	Salk Vaccinated			
			1 or More Doses	3 Doses	4 Doses	3 or More Doses
1957	2158[1]		658[2]			206[2]
1958	3122[1]	45%	571[3]	237[3]	10[3]	247[3]
1959	5694[1]	164%	1870[4]	750[4]	178[4]	928[4]

1. National Office of Vital Statistics figures: Morbidity and Mortality. USPHS vol. 8, no. 52 (Jan. 8) 1960.
2. Polio Surveillance figures: Thrupp, Lauri D., et al.: Poliomyelitis in the United States, 1957. Public Health Reports 74:535-545 (June) 1959.
3. Polio Surveillance figures: Polio Surveillance Unit Report No. 160. Dec. 5, 1958. These figures are only through Nov. 20, 1958. Also omitted are cases of paralytic polio among 179 cases for which age and/or vaccination status are unknown. The true figures are higher.
4. Polio Surveillance figures: Polio Surveillance Report No. 197. May 16, 1960.

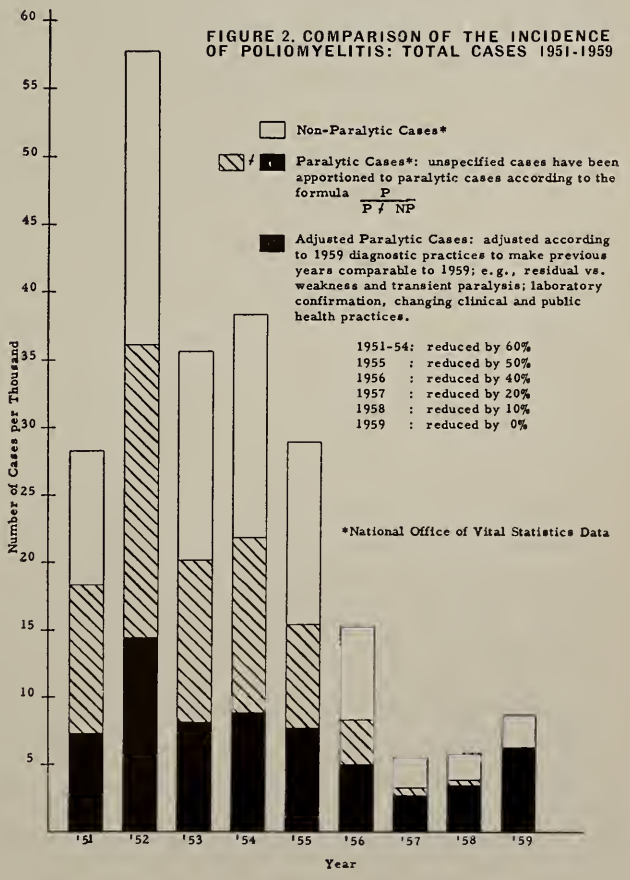
These figures do not include cases of paralytic polio among 237 cases for which PSU did not receive any separate reports, in 184 cases in which the vaccine status was unknown, and in an unknown number of cases whose original diagnosis was changed as a result of "a 60-day follow-up report which included a verification of the diagnosis, (and) an estimate of the severity of residual paralysis." "The paralytic category (now) includes 4,783 cases with residual paralysis at sixty days plus 689 cases with a preliminary diagnosis of paralytic poliomyelitis for which no follow-up data were received." That the switch from paralytic cases to nonparalytic cases on the basis of the absence of residual paralysis in those with 3 or 4 doses of Salk vaccine is considerable may be gathered by comparing the final report on 1959 (Report 197), which includes follow-up data through Feb. 29, 1960, with the preliminary report in an earlier PSU Report (No. 193), which includes follow-up data through Jan. 11, 1960. This should be understood in the light of Dr. Langmuir's remark to state epidemiologist in his letter of Sept. 29, 1959, that, "In the final analysis, even a small number of corrections may make crucial differences in the evaluation of effectiveness of vaccine. A revoked diagnosis or a switch of diagnosis from paralytic to nonparalytic, or vice versa, in only 5 to 10% of cases could change basic conclusions remarkably."



up to actuality, and Dr. Langmuir was right when he said the figures of 1959 were sobering.

In preparation for the discussion, it was thought best to review some basic facts of polio: incidence, natural history, the disease, and immunity, all important to the understanding of the vaccine problem. Table 1 presents current data on incidence of paralytic polio. Figure 1 presents the natural variations in incidence of polio and infectious hepatitis. Both diseases were in a natural decline when the Salk vaccine was introduced in 1955. Since the wide acceptance of the Salk vaccine was based primarily on the sharp decline in polio incidence, it is important to keep in mind that infectious hepatitis equally declined following the Salk vaccine.

Figure 2 shows what the incidence of paralytic polio would have been from 1951 through 1959 if the figures were corrected for the radical changes in diagnostic criteria since the introduction of the Salk vaccine. Dr. Greenberg will discuss some of these changes later. The solid columns in figure 2 represent a conservative estimate of what the incidence of paralytic polio would have been in former years if the diagnostic criteria of 1959 had been used. This permits a



more accurate comparison. It also helps us evaluate the progress or lack of progress made since the introduction of the Salk vaccine.

The low incidence of the disease also complicates evaluation of a vaccine. Presently, a community is considered to have an epidemic when it has 35 cases of polio per year per 100,000 population.* In Oak Park with a population of 61,000, 21 or more cases constitutes an epidemic. Since Oak Park has about 500 blocks, this means one case of polio per year to 25 blocks. We have had only one epidemic of polio in the recorded history of Oak Park. In a high incidence disease like measles, on the other hand, it is common to have 21 cases in a single block. The difficulty in evaluating the efficacy of a vaccine against polio as contrasted to measles is obvious.

Because of the low incidence of polio, neither the private physician nor the local public health physician is in a position to judge the value of polio vaccine from personal experience alone. One central source must collect and evaluate the data. The result will be only as good as the thoroughness, objectivity, and statistical skills of the central source. Part of the difficulty in the evaluation of the Salk vaccine has been that the responsible authorities have not refined the techniques for evaluating high incidence diseases so that they can be applied to low incidence diseases.

We must also distinguish between polio infection and the clinical disease. Tuberculosis, where we have the tuberculin reactor which signifies infection as contrasted to the reportable clinical disease, is the prototype. For every one case of known paralytic polio we have about a thousand cases of subclinical polio infections. The latter accounts for the high degree of natural immunity in adults. Crucial to the understanding of the contemporary vaccine problem is that you can get infection of the gut with or without disease.

The theory of the killed vaccine is that circulating antibodies in sufficient amounts will neutralize poliovirus before it reaches the central nervous system. One of the major disappointments of the killed vaccine is that circulating antibodies alone do not protect against alimentary infection. Only when the local immunity follows an alimentary infection are we capable of achieving a more consistent immunity against the disease. Circulating antibodies produced by a killed vaccine do not prevent the multiplication of enormous numbers of poliovirus in the gut, nor their break through into the circulatory systems. Protection depends on the presence of circulating antibodies in sufficient titer to offset virus entering the circulatory systems. Immunity of this type is predominantly relative.

This concludes our review. Dr. Greenberg will launch us into our panel discussion.

Dr. Bernard Greenberg: I agreed, as a participant of this panel, to discuss the present status of the Salk vaccine *as a statistician.* As such, my primary concern, my only concern, is the very misleading way that most of this data has been handled from a statistical point of view.

There has been a rise during the past two years in the incidence rates of paralytic poliomyelitis in the United States. The rate in 1958 was about 50 per cent higher than that for 1957, and in 1959 about 80 per cent higher than in 1958. If 1959 is compared with the low year of 1957, the increase is about 170 per cent. At the same time, the rates for nonparalytic polio have been declining in relation to the 1957 base.

As a result of this trend in paralytic poliomyelitis, various officials in the Public Health Service, official health agencies, and one large voluntary health organization have been utilizing the press, radio, television, and other media to sound an alarm bell in an heroic effort to persuade more Americans to take advantage of the vaccination procedures available to them.

Although such a program might be desirable until live virus vaccines are available to us on more than an experimental basis, the misinformation and unjustified conclusions about the cause of this rise in incidence give concern to those interested in a sound program based on logic and fact rather than personal opinion and prejudice.

One of the most obvious pieces of misinformation being delivered to the American public is that the 50 per cent rise in paralytic poliomyelitis in 1958 and the real accelerated increase in

**Prior to the introduction of the Salk vaccine the National Foundation defined an epidemic as 20 or more cases of polio per year per 100,000 population. On this basis there were many epidemics throughout the United States yearly. The present higher rate has resulted in not a real, but a semantic elimination of epidemics.*

1959 have been caused by persons failing to be vaccinated. This represents a certain amount of "double talk" and an unwillingness to face facts and to evaluate the true effectiveness of the Salk vaccine. It is double talk from the standpoint of logical reasoning: If the Salk vaccine is to take credit for the decline from 1955-1957, how can those individuals who were vaccinated several years ago contribute to the increase in 1958 and 1959? Are not these persons still vaccinated?

The number of persons over two years of age in 1960 *who have not been vaccinated* cannot be more, and must be considerably less, than the number who had no vaccination in 1957. Yet, a recent Associated Press release to warn about the impending threat referred to the idea that the "main reason is that millions of children and adults have never been vaccinated." If they were never vaccinated, undoubtedly many more than were reported were unvaccinated during 1955, 1956, and 1957 when the same officials were claiming that reduction in rates was due to the vaccine.

Could it be that the vaccine has been only a temporary stop-gap and that the effect is now wearing off because the vaccinated individuals are not maintaining their antibody status through subclinical exposures and booster doses?

One cannot answer this question in the negative with real assurance because such a possibility is certainly a real one. The reduction of antibody titer with time is well documented and may explain why some individuals vaccinated five years ago have lost their immunization status. On the other hand, officials urging vaccination have taken the stand that the rate increased because large segments of the American population, about 49 per cent, have had no vaccine at all!

A scientific examination of the data, and the manner in which the data were manipulated, will reveal that the true effectiveness of the present Salk vaccine is unknown and greatly overrated.

The remainder of this paper documents this statement.

Effectiveness of Salk vaccine

All here will remember that the field trials in 1954 showed that the vaccine used was 72 per cent effective in preventing paralytic poliomyelitis within one year, but completely ineffective in preventing nonparalytic poliomyelitis.[5] It must be remembered that these figures apply to the vaccine used in 1954, and, therefore, all the Francis report really tells us is that the Salk vaccine of 1954 was 72 per cent effective in preventing paralytic poliomyelitis for that one season.

For the 1955 vaccine, certain changes in the manufacture and testing for safety were introduced. The vaccine did not contain merthiolate as did the 1954 product. Live viruses were found in several lots, and the foundation of Salk's theory of inactivation was questioned. We were alarmed by the variation in antigenic potency of different lots from different manufacturers especially for a product that was to be administered on a mass basis. The Cutter incident and the White Paper[6] are clearly remembered by those of us who, at that time, questioned the wisdom of the program as it was being conducted. To insure "absolute safety," an extra filtration step was introduced in November, 1955.[7] Perhaps Dr. Cox will comment on what this extra filtration step may do to the antigenic potency of the vaccine.

The result of that change, as well as the preceding ones, upon the effectiveness of the present vaccine is unknown. At that very time—November, 1955—the Poliomyelitis Surveillance Unit of the Communicable Disease Center published a paper which purported to show that in 1955 the vaccine was still as effective as in 1954.[8] In fact, a report from that unit on Dec. 7, 1955, went so far as to claim that a single inoculation of the vaccine was about 78 per cent effective in preventing paralytic poliomyelitis![9]

In care and precision, the method of study in this Public Health Service report was not at all comparable to that of the field trials of 1954. There were no controls, the data were retrospective, and there were no rigid diagnostic criteria that could be supervised on a national basis. The claim that one inoculation was 78 per cent effective was too much for anyone to accept.

We were able, fortunately, to conduct a more intensive study in North Carolina, but it was subject to the same limitations of no real controls, and of retrospective design. Our purpose was simply to learn the magnitude of the bias introduced by faulty statistical manipulations in the Poliomyelitis Surveillance Unit study. We found that one dose was practically ineffective and two doses would produce a figure of only

about 60 per cent reduction among children 5 to 9 years old. The Poliomyelitis Surveillance Unit study had reported about 80 per cent effectiveness in North Carolina for a single shot. Why this discrepancy of figures in the two studies?

In a paper on the results of our study delivered before the Biometric Society and Institute of Mathematical Statistics in April, 1956,[10] I pointed out that the discrepancy was purely a statistical one. There were two biases in the way the Public Health Service had calculated its rates of attack among the vaccinated and the unvaccinated.

First of all, the unvaccinated population figure for 5 to 9 year old children used in the Public Health Service report was the number given in the 1950 census minus the number of children vaccinated. The number of children aged 5 to 9 in 1955 was estimated, however, to be 101,000 more than it was in 1950. The Public Health Service did not take this increase into account. The omission of 101,000 children from the unvaccinated population would have increased the latter roughly from 236,000 to 337,000 children. Hence, the attack rate for unvaccinated children was overestimated by about 40 per cent.

The second bias in the way the Public Health Service had calculated rates involved the period of exposure for the vaccinated children. As the children were vaccinated each month, they were transferred to the vaccinated group piecemeal. Before children can be moved to the vaccinated status, however, one must consider the length of time they remained in the nonvaccinated group before transference. In the adjustment process, the seasonal incidence of the disease also must be considered. To obtain correct estimates of the population who had "one and only one" inoculation of vaccine, this adjustment process must be used, not only to transfer first vaccinees into that group, but also to transfer out those children who obtained second inoculations. Failure to do so by the Public Health Service accounted for the remainder of bias between the two studies. Hence, as far back as 1955 and before the extra filtration step was introduced, the question of whether the Salk vaccine was really as effective as it was in 1954 could not be answered.

Reasons for recent increase

If the vaccine was not as effective, one might wonder why the tremendous reduction occurred in the 1955, 1956, and 1957 reported rates. Here, again, much of this reduction was a statistical artifact.

Prior to 1954 any physician who reported paralytic poliomyelitis was doing his patient a service by way of subsidizing the cost of hospitalization and was being community-minded in reporting a communicable disease. The criterion of diagnosis at that time in most health departments followed the World Health Organization definition: "Spinal paralytic poliomyelitis: Signs and symptoms of nonparalytic poliomyelitis with the addition of partial or complete paralysis of one or more muscle groups, detected on two examinations at least 24 hours apart."[11]

Note that "two examinations at least 24 hours apart" was all that was required. Laboratory confirmation and presence of residual paralysis was *not* required. In 1955 the criteria were changed to conform more closely to the definition used in the 1954 field trials: residual paralysis was determined 10 to 20 days after onset of illness and again 50 to 70 days after onset. The influence of the field trials is still evident in most health departments; unless there is residual involvement at least 60 days after onset, a case of poliomyelitis is not considered paralytic.

This change in definition meant that in 1955 we started reporting a new disease, namely, paralytic poliomyelitis with a longer lasting paralysis. Furthermore, diagnostic procedures have continued to be refined. Coxsackie virus infections and aseptic meningitis have been distinguished from paralytic poliomyelitis. Prior to 1954 large numbers of these cases undoubtedly were mislabeled as paralytic poliomyelitis. Thus, simply by changes in diagnostic criteria, the number of paralytic cases was predetermined to decrease in 1955-1957, whether or not any vaccine was used. At the same time, the number of nonparalytic cases was bound to increase because any case of poliomyelitis-like disease which could not be classified as paralytic poliomyelitis according to the new criteria was classified as nonparalytic poliomyelitis. Many of these cases, although reported as such, were not nonparalytic poliomyelitis. If this inaccurate number of cases of nonparalytic poliomyelitis reported in 1957 is accepted as accurate and considered as a base for subsequent comparisons, it is no wonder that we now say nonparalytic cases went down in 1958.

There is still another reason for the decrease in the reported paralytic poliomyelitis cases in 1955-1957. As a result of the publicity given the Salk vaccine, the public questioned the possibility of a vaccinated child developing paralytic poliomyelitis. Whenever such an event occurred, every effort was made to ascertain whether or not the disease was truly paralytic poliomyelitis. In fact, I am certain that many health officers and physicians here will ask routinely if a child has been vaccinated when signs of poliomyelitis are present during the summer months. We have been conditioned today to screen out false positive cases in a way that was not even imagined prior to 1954.

As a result of these changes in both diagnosis and diagnostic methods, the rates of paralytic poliomyelitis plummeted from the early 1950's to a low in 1957.

Why then has there been a recent increase since 1957?

Why have the improved methods of diagnosis not prevailed during 1959 and 1960?

The improved methods of diagnosis have prevailed. The present increase, I believe, is caused by a long-term, increasing trend in the incidence of the condition or disease we now call paralytic poliomyelitis. Without doubt, the increasing trend has been reduced to some extent by the Salk vaccine. Nevertheless, the Salk vaccine has limited effectiveness in its ability further to reduce this trend. The reduction at the outset appeared to be much more effective than it was, because the early years of the vaccine's use were clouded by reduction in reported incidence by the elimination of the false positives. However, any future substantial reduction in this trend will require a more potent vaccine, not simply vaccinating more people. If there were no other vaccine, complete vaccination of all susceptible persons in the population with Salk vaccine would be justifiable.

Delays in accepting the new live virus vaccines may result in a continuation of the trend observed in 1959. Today it may be a serious mistake to be ultraconservative in accepting the new live virus vaccines under the impression that there is no hurry because an almost equivalent immunizer exists in the Salk vaccine. A delay in accepting and promoting better vaccines will be a costly one. There must be immediate pressure applied to determine whether or not the new vaccines are more effective, so that we do not cling, for sentimental or personal reasons, to an older vaccine whose true effectiveness is today unknown.

QUESTION: Are antibody levels any indication of the reliability of the effectiveness of the vaccine?

DR. COX: The only way you really can determine vaccine effectiveness is by direct challenge. Obviously, in polio you cannot make a direct challenge on man. We know, however, from experience with other vaccines that the most accurate indirect method we have is measuring the levels of neutralizing antibodies in the blood, and that's what we're checking.

It is well accepted now that this method represents a spillover of antibodies produced in the tissue. We do not know, however, the exact level of neutralizing antibodies necessary to protect against paralytic polio. There is increasing evidence that antibody levels as low as 1:4 are significant. Complement-fixing antibodies, on the other hand, are not a reliable index of effectiveness, nor do they necessarily correlate with neutralizing antibodies.

DR. KLEINMAN: Dr. Ratner has put me in the position of Devil's Advocate, being the only one on the panel who at one time committed himself in writing that the Salk vaccine was quite effective. Back in 1958 we showed, or thought we showed, that two doses of Salk vaccine was 83 per cent effective in preventing paralytic polio. We thought this was done rather carefully using a Life Table method of analysis which recognizes that the population at risk changes week by week and month by month. We did not, however, as Dr. Greenberg suggested, give special weight to those months of the year in which the risk of contracting polio is greatest.

We repeated this study of 1955 and 1956 by projecting the same type of statistical analysis into 1957.[12] Lo and behold, we found that two doses of Salk vaccine was not nearly as effective in 1957 as we thought it was in 1956. Instead of 83 per cent effectiveness, we found only about 24 per cent. Further, in 1957 we found that it took three doses to come close to the effectiveness that we had demonstrated with two doses in 1956.

But let's leave that aside. Let me tell you why, aside from the statistical standpoint, I'm getting nervous about the Salk vaccine. My first reason is the definite increase in paralytic polio. In Minnesota we have found that 20 per cent of our 1959 paralytic experience has occurred in triple and quadruple vaccinates. At present, I am an agnostic as far as the efficacy of the Salk vaccine is concerned because I do not *know* how effective it is. I believe it has some degree of effectiveness, but I do not know the extent because I cannot get proper denominators. A denominator which consists of a point determination of the number of vaccinates as compared to the unvaccinates is absolutely useless because it ignores the changing character of the risks involved. These risks vary from day to day depending upon the seasonal peculiarities of polio infection and the changing character of the Salk vaccinated population.

Laboratory findings are another reason why I am getting nervous. If polio antibodies mean anything in respect to protection, then I am forced to conclude that much of the Salk vaccine we have been using is useless. For two years now we have done antibody titrations on children who have received three or more doses of Salk vaccine. These titrations show that over 50 per cent do not have antibodies to Types I and III and that 20 per cent lack antibodies to Type II poliovirus.[13] This is a very disturbing fact. When a phenomenon like this occurs two years in a row, one has reason to believe that the material we are injecting is not an antigenic preparation.

I should also like to emphasize Dr. Greenberg's remarks on the changing concepts of polio. It is now extremely difficult to get a Minnesota physician to make a preliminary diagnosis and report of nonparalytic polio. We now know that aseptic meningitis has a much broader etiology than poliovirus. In 1956 in much of our so-called nonparalytic polio, the etiology turned out to be Coxsackie B-5 virus, and in 1957 a staggering outbreak turned out to be Echo 9 virus. It is no wonder then that the average doctor does not want to make a diagnosis of polio in the absence of frank lower motor neuron flaccid paralysis. As a result, the only polio that's being reported today are cases with frank paralysis.

I would also like to agree with Dr. Greenberg that the insistence upon a sixty day duration of paralysis for paralytic polio is absolutely silly. There isn't a doctor in this room who hasn't seen a case of frank paralytic polio which has not recovered within sixty days, or at least recovered sufficiently so that you could not estimate with clinical certainty that there was some residual paralysis.

I would like, then, to have my position understood, at least on this panel, as that of an agnostic so far as the Salk vaccine is concerned. I am not against it. I think it is the only medium we have which has some degree of reliability; but I think there are better methods, and I think we should take advantage of these methods if it seems at all reasonable.

Dr. Ratner: Dr. Cox, what has been your experience with antibody findings in triple or quadruple Salk vaccinates?

Dr. Cox: First let me say that I am convinced that living virus vaccine is going to be the final answer. I base this statement on my experience in the virus field since 1928. I am not against killed virus vaccines. I was the first person to prove that they could be made. This was at the Rockefeller Institute, where I developed a killed vaccine against eastern equine and western equine encephalomyelitis.[14] Later, as a bacteriologist at the USPHS, I produced other killed vaccines.[15]

I want to emphasize, however, that everything done in the field of virology has to be quantitative. This applies to living as well as killed virus vaccines. Unless you have quantitative methods and know what you are putting into a vaccine product, you have nothing. The reason our company refused to make the killed Salk vaccine was because we knew it was impossible to produce enough virus by known tissue culture methods to make a good killed poliovirus vaccine. We knew the quantitative requirements for vaccine as far back as 1934. Dr. Salk has admitted this past year that this principle is true. This basic quantitative principle is precisely applicable to polio. I am anxious to tell you what we know.

There are very few things that you can generalize upon in this field, but one thing you can depend on is that you've got to have at least 100 million particles per dose to make a killed vaccine that's worth anything. The only single exception is Rocky Mountain spotted fever vaccine, which has by far the best antigen that

anybody has ever found, either in rickettsiology or virology. With spotted fever you can make a good killed vaccine with between 10 and 30 million rickettsial particles, but in the case of viruses you must have 100 million virus particles, as a minimum, and preferably a higher concentration.

We have found that in production—all the manufacturers have found this—you never get much above 10 to 30 million poliovirus particles per cc. by tissue culture methods. Accordingly, we told our company that to make a good killed virus product we would have to concentrate the vaccine from five to tenfold for a product that would meet our standards. Otherwise, we would be producing a product that a true scientist could not be proud of, and we didn't want to be in a position where we could not back the product. It costs the manufacturer around 39 cents a cc. to make the present killed vaccine. If you multiply that by five to tenfold and include the additional labor costs, you can see that the product would be costly. We predicted this back in 1950 when we decided not to produce Salk vaccine.

We are now learning, not only in the United States but in Israel, England, and Denmark, that the killed product does a fairly good job of producing antibodies against Type II poliovirus. But Type II represents only about 3 per cent of paralytic cases throughout the world. The killed vaccine does a poor job against Type I, however, which causes 85 per cent of paralytic cases, and against Type III, which causes about 12 per cent. In other words, the killed vaccine is doing its best job against the least important type. It took time to find this out. It was proven in Israel in 1958, when it had its big Type I epidemic.[16] They did not see any difference in protection between the vaccinated and the unvaccinated. Last year in Massachusetts during a Type III outbreak, there were more paralytic cases in the triple vaccinates than in the unvaccinated.[17] Actually, there is a very good but little known immunological explanation for this.

Dr. Kleinman, in referring to the Minnesota studies, did not specify that in the triple Salk vaccinates 57 per cent had antibody titers of less than four to Type I poliovirus, 20 per cent had the same lack of antibody titers to Type II poliovirus, and 77 per cent had titers of less than four to Type III poliovirus, as of January and February, 1958. We found the same thing in Pearl River personnel.[18] The amazing thing is that when you analyze these 1,100 people scattered in northern New Jersey and southern New York, you find no appreciable difference between the response of the unvaccinated and the vaccinated, following three or four injections, to Type I or III poliovirus.

Question: At what intervals after the last injection did you make these antibody studies?

Dr. Cox: These vary, but they're all within a period of 18 months. Of course, the claim has been made that a good killed Salk vaccine should give a longer duration of immunity. I don't know of any killed vaccine that gives a longer duration of immunity. I do know that in Rocky Mountain spotted fever, which has a mortality rate of 95 per cent, the vaccine has eliminated mortality, provided booster doses are taken once a year. The same thing is true with epidemic typhus vaccine. Both of these are very good killed vaccines. I know of none better; yet the immunity they provide is of short duration and requires yearly boosters.

Dr. Ratner: Dr. Cox, would you relate the effect of the additional filtration step, which was introduced as a necessary safety measure in November, 1955, on the production of a potent Salk vaccine?

Dr. Cox: The extra filtration step was introduced because the amount of formalin used in preparing the vaccine did not inactivate the poliovirus. We found residual live virus for as long as 42 consecutive days of inactivation. It is common knowledge in the industry that the regulations requiring incubation for 10-day intervals did not eliminate residual live virus. The manufacturers, through difficulties encountered in production, soon learned of this and, to be sure there was no live virus, extended the period of cooking to 30 days or more. Even then they had to throw out batches, because polio is one of the most difficult viruses to inactivate with formalin.

The second filtration step was picked out of thin air with no experimentation to back it up. Because it was thought that residual live virus particles encased in a mass of killed particles were getting through, the filtration step was introduced in the hope that it would remove this aggregate. We've known for years, however, that

any time you introduce an additional filtration step you lose antigen. Actually, the Israelis found they lose from 10 to 30 fold in virus content by a second filtration step.[19] If you have a small amount of antigen to start with, additional filtration will only reduce it still further. Certainly, this vaccine has been most confused because of many vested interests, but on a scientific basis any virologist will agree that I'm telling you the absolute gospel.

Question: Do you know the variation of the potency of the Salk vaccine on the market?

Dr. Cox: Unfortunately, that varies considerably. The manufacturers are unable to quantify virus particles in the killed vaccine because it is too costly. A good killed vaccine requires a standard, consisting of the number of virus particles of the strain being used. This standard, of course, will vary with the strain used in both killed and live vaccines. From experience we know that it is wise to have a highly virulent strain for good antibody response. That's why the Mahoney strain, which is highly virulent in monkeys, was chosen as the Type I component of the Salk vaccine. As little as five virus particles of Mahoney injected intramuscularly will paralyze monkeys.

This virulent strain, however, was responsible for the vaccine-induced outbreaks in the spring of 1955. In Idaho, where the people were polio virgins, the vaccine caused numerous cases of polio. In New Mexico, Arizona, and elsewhere, where natural immunity was present, there were few or no cases.

Dr. Ratner: Some specific data on the variation in potency may be of interest. New York State Health Department investigators reported in September, 1956, that there was a six-hundredfold variation in the potency of commercial Salk vaccine on the market.[20] Other unpublicized USPHS data showed a sixtyfold variation.[21] Today many inoculations of the Salk vaccine are needed to accomplish the same results that were claimed in 1955 with one inoculation. In the history of drug therapy there are few drugs, if any, which become progressively inferior with increasing years.

Dr. Cox: I would like to repeat that good vaccine, whether living or killed, has to be quantified. Our living poliovirus vaccine, which I hope to tell you about very soon, is quantified. We keep very careful control of the exact amount of virus in every drop we produce.

In virology you have to deal with both quantity and quality. If both are under control, you're on solid ground. If they are not under control, you don't know where you are.

Dr. Ratner: To close the discussion on potency, back in May, 1957, the largest producer of Salk vaccine in the United States had several million dollars worth of vaccine on hand which did not pass the minimum potency requirements of the USPHS. Subsequently, the Division of Biological Standards reinterpreted the minimum requirements to make possible the commercial utilization of this vaccine.[22]

We would now like to spend a little time on the safety factor.

Dr. Meier: The thing that impresses me most about this question of polio vaccine is a problem that has been discussed only by indirection. How is it that today you hear from the members of this panel that the Salk vaccine situation is confused; yet what everybody knows from reading the newspapers, and has known since the vaccine was introduced, is that the situation as far as the Salk vaccine is concerned was and is marvelous? The reason for this discrepancy lies, I think, in a new attitude of many public health and publicity men. It is hard to convince the public that something is good. Consequently, the best way to push forward a new program is to decide on what you think the best decision is and not question it thereafter, and further, not to raise questions before the public or expose the public to open discussion of the issues.

My own contact with this attitude came when I was a member of the Department of Biostatistics at Johns Hopkins, where I had an opportunity to talk with some of the people who were connected with the vaccine. My interest was stimulated by several papers[23] on the safety of the vaccine written by Salk preparatory to the 1954 field trials.

The general theory that Salk was working on was a very simple and old one: that the inactivation of poliovirus by formalin would proceed in a straight-line, first-order reaction. This means that in x hours of contact with formalin, half the virus particles would be inactivated, that

an equal number of additional hours would inactivate another half of the remaining live virus particles and so on. By extending the period of inactivation, a product would result in which the amount of living virus remaining was necessarily so minute as to have no practical significance. This was Dr. Salk's built-in-safety factor to insure complete safety.

Although this theory applies to many cases, whether it applies to the Salk vaccine remains an empirical question. What troubled me greatly was that it appeared from actual data which Salk presented that the theory did not apply. Assuming there was some error in my understanding or in Salk's, I inquired of the people who knew about this. The answer I consistently received was "I see what you mean. I haven't thought about it very carefully myself, but there are many important and competent people who are taking care of this. Don't worry. After all, this is merely a paper for the public and not the real technical goods." The answer as it emerged later, of course, was no one was taking care of it.

The problem of making a new vaccine, or adopting any public health measure, will always be difficult. We have to be prepared to move ahead in face of the risk of error. In this particular issue, what troubled me was moving ahead when the error was there before us in the paper that undertook to demonstrate safety.

The reason for this unhappy situation lies first in the attitude I referred to earlier: that dissent and discussion in public are unwelcome. Secondly, I think it lies in the diffusion of responsibility that has resulted from the committee system of promoting new measures. In this case a large committee was involved, but no single member took it upon himself to check the problem all the way through. Although Dr. Salk felt he had, no one else double checked him. Even more serious evidence than that which Salk provided in public emerged later: the presence of live virus in vaccine manufactured in strict accordance with the protocols.[24] To be sure, these lots of vaccine were not distributed for the field trials in 1954. Notwithstanding, this experience demonstrated unequivocally that the method itself was not safe. Futhermore, most of you know that the triple safety checking of the vaccine used in the field trials by the manufacturer, Dr. Salk's laboratory, and the Public Health Service was dropped in the licensing procedure. Most of the lots distributed in 1955 were tested only by the manufacturer. It was no surprise, then, that we had a spring outbreak of vaccine-induced cases. The only suprise was that there weren't more.

(*To be concluded*)

REFERENCES

A bibliography is available on request.

Health man-power only one-tenth physicians

The latest *Health Man-power Chart Book* of the United States Department of Health, Education, and Welfare states, "Nearly two million persons are employed in occupations considered in the health field." Among these are dentists, public health nurses, health engineers, health educators, medical and psychiatric caseworkers, nutritionists, sanitarians, and laboratory technicians. Of the nearly two million health workers, perhaps less than two hundred thousand are practicing physicians. *Hugh A. Matthews, M.D. The Role of a Physician in a Changing Society. North Carolina M.J. Feb. 1960.*

Hazards of Anticoagulant Therapy*

E. L. Borkon, M.D. *Carbondale*

The present enthusiasm for anticoagulants in the acute and long term treatment of myocardial infarction and thromboembolic complications appears justified.[1-6] That this enthusiasm is tempered with reservations by some authorities does not prevent those with less enthusiasm from using anticoagulants. The less enthusiastic may use anticoagulants in their "good risk" but not "poor risk" patients with acute infarctions.[6-13]

Since Link, in 1944, reported the anticoagulant effect from spoiled sweet clover,[15] the discussion has waxed hot and cold.[16] Prevalent practice is to use anticoagulants, especially in myocardial infarction, irrespective of a "good" or "poor" risk diagnosis.[8,17]

Of 32 cases we have had on anticoagulant therapy (mostly on Coumadin® or Dicumerol®), eleven have had some type of complication. Hematuria occurred in six, petechiae of the skin in three, and hemoptysis and gastrointestinal bleeding in one each. All complications were easily controlled by reducing the dosage of anticoagulant or by the use of vitamin K-1, except in the two instances reported in more detail.

Case 1

J.K.J. was a 62 year old white male with a thrombosis of the central artery of one eye and early glaucoma of the other eye. His ophthalmologist strongly urged anticoagulant therapy to prevent further thrombosis. Coumadin was started. He had hematuria when the prothrombin was 25 seconds (control—12 seconds). The Coumadin was withdrawn and vitamin K-1 given at once; bleeding stopped. Thorough re-examination and genitourinary consultation revealed no immediate reason for the hematuria. Because of the patient's insistence that something be done rather than take the chance of further retinal arterial thrombosis, anticoagulant therapy was resumed at a more conservative level. With the control at 12 seconds and the patient at 18 seconds, he again developed hematuria.

This time vitamin K-1 and fresh whole blood did not stop the hematuria. Cystoscopic examination was of no help, and the patient continued to pass blood and clots. An inlying Foley catheter was inserted to prevent bleeding and urinary obstruction by clots. Three weeks later a prostatic abscess was found and drained, and the bleeding and urinary symptoms abated.

This patient bled at a prothrombin time considered well below the danger level. Presence of the prostatic abscess seemed to be the complicating factor.

Case 2

P. W., a 61 year old patient with diabetes and two attacks of myocardial infarction, was placed on long term anticoagulant therapy. With a control prothrombin time of 13 seconds and his own time at 26 seconds, he developed large tender ecchymoses on his abdomen, thighs and arms—sites of insulin administration. Re-examination for possible complicating factors was negative. Anticoagulant therapy was maintained at a lower level, 5 to 7.5 mg. of Coumadin daily, to produce a prothrombin time of 18 to 22 seconds with a control of 12 to 13. At this level, further ecchymoses were seldom encountered, and the patient has had no further myocardial infarction in four years. The patient had a marked sensitivity to the anticoagulants.

Case 3

A 90 year old woman with arteriosclerotic heart disease, auricular fibrillation, and bronchiectasis developed multiple emboli to the brain, lung, and finally the left popliteal artery, with impending pedal gangrene. One dose only of 25 mg. of Coumadin elevated her prothrombin time to 45 seconds from a pretreatment level of 14

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seconds. No further anticoagulant was given at any time. In the succeeding five days the thrombosis did not progress, but the prothrombin time failed to fall below 42 seconds, in spite of vitamin K-1 emulsion in 50 mg. intravenous dosage. On the sixth day the patient developed a hemorrhagic diarrhea and exsanguination, in spite of the vitamin K and transfusions. Autopsy was not obtained. The reason for the abnormal response to one dose of Coumadin is unknown. The numerous other diseases and long-standing bronchiectasis may have accounted for the patient's sensitivity as a result of old damage to the liver.

Case 4

This case exemplifies a patient who recovers from an acute attack of myocardial infarction and then is advised to stay on anticoagulant therapy. He gains more than merely a drug effect from the use of the substance — he gains a great confidence in staying well by continuing to use the drug that brought him through his heart attack. The psychotherapeutic effect of continuing the medication may be so great that occasionally he will study the drug effect himself. He may assume that he knows enough to supervise his own administration. Why bother the physician to govern the daily dose needed to increase his prothrombin time when he can do it on his own? Finding a congenial druggist who honors his doctor's original prescription without question over the years facilitates the patient's running his own anticoagulant program. Such a case illustrating the hazard of self-medication with anticoagulant therapy, plus late diagnosis of the cause of bleeding, and perhaps, failure to give vigorous enough therapy[18] make up the subject of this final case report.

Mr. F. F., a 78 year old retired zoology professor, was admitted to the hospital with urinary retention and bloody urine. After he was seen in consultation the next day, a more complete history was obtained from his family since he was confused though garrulous, and his own story unreliable.

The patient's family brought him to the hospital because he complained of shortness of breath and chest pain, vomited coffee-ground material, and passed tarry stools and dark urine. Four weeks prior to admission the patient had noted bloody urine. His local doctor had diagnosed this as prostate trouble. The hematuria had been treated with medicine of unknown nature, both self-prescribed and doctor-prescribed. At least one indication was "Six Drops" — a compound containing wintergreen. Hematuria ceased one week before, only to return the day prior to admission. The point of greatest significance was that the patient induced his local doctor to prescribe "blood-thinning medicine" for some time. To the family's knowledge no prothrombin measurements had been obtained recently. Furthermore, it could not be accurately ascertained if within the past two years any prothrombin-time evaluation had been made. The patient had a double herniorrhaphy in 1942, and nine years before that, a transurethral resection of the prostate gland. During the first surgical procedure the patient sustained either a myocardial infarction or a pulmonary embolus, the relatives were not certain which.

In 1953, because of acute urinary retention, he had a second resection of the prostate gland. The blood urea nitrogen was reported as 35 at that time, and a 1-plus albuminuria was recalled. An electrocardiogram was said to have revealed 2:1 heart block. Ever since the 1953 episode the patient was said to have induced his family physician to give him Dicumerol. As far as can be learned, prothrombin checks were not obtained.

Examination and treatment

Physical examination revealed a pale, white male with large ecchymotic areas below the left ear and extending into the neck and on to the left shoulder area. Similar lesions the size of dinner plates were on both thighs. The heart was enlarged to the left anterior axillary line, and the pulse was 48 at the apex.

The initial blood pressure was 90/60 mm. Hg, but increased to 136/60 after intravenous fluid administration. The lungs were clear throughout. A knobby, hard liver extended two finger breadths below the right costal margin.

Initial laboratory findings were hemoglobin 10.6 Gm. (65.6%) and 3,500,000 red blood cells, with a hematocrit of 35 per cent. The hemoglobin the next day, after transfusion and some fluid administration, was surprisingly even lower at 7.9 Gm. and 2,110,000 red blood cells. The urine specific gravity was 1.009 per cent; albumin, 2 plus; microscopic 2-4 red blood cells, 15-20 white blood cells per high power field.

A Foley catheter, inserted on admission, drained bloody urine with many clots.

The initial diagnosis before the complete history was obtained from the family regarding the taking of "blood-thinning medicine" was a possible cirrhosis of the liver with an accompanying carcinoma of the liver considered. Added to this was the possibility of esophageal varices and acute urinary retention from prostatic hypertrophy. The diagnosis after the additional history was modified to Dicumerol poisoning with a 2:1 heart block, arteriosclerotic heart disease, and old myocardial infarction.

The patient's course in the hospital was stormy. The morning after admission the blood urea nitrogen was 41, and the blood sugar was 184 mg. per cent. Bleeding and coagulation times were normal. The platelet count was normal at 259,000. The prothrombin time was elevated to 31 seconds with a control of 11.5.

Daily prothrombin times obtained thereafter, in spite of vigorous vitamin K-1 therapy and transfusion, continued high at 34, 39, and 45 seconds with the control remaining in the 11-second range. On the day of the patient's death the prothrombin time had dropped to 14.5 seconds, almost to the normal level.

In the hospital the patient received a total of three pints of whole blood, the last pint on the day of his death. This was in addition to the 50 mg. of vitamin K-1 admininistered intravenously on each of the last two days.

Autopsy revealed only two old myocardial infarctions and huge quantities of free, unclotted blood in the thoracic cavity, the abdomen, the viscera, the bladder, and in most of the tissue examined. The pathologic diagnosis was myocardial anoxemia secondary to hemorrhage and anemia with Dicumerol poisoning, and hemosiderosis of the liver.

Discussion

It is of interest to note that in chemical structure Dicumerol and vitamin K (bishydroxycoumarin) are similar. This may explain the action of Dicumerol in the liver. There may be a competition for the hepatic utilization of vitamin K for the synthesis of prothrombin.[16] It is recognized that one 50 mg. dose of intravenous vitamin K-1 inhibits the effect of Dicumerol for approximately one week. The principal known action of Dicumerol is to inhibit blood coagulation by causing a depression of the prothrombin in the blood. Dicumerol takes 12 to 24 hours to act in vivo; the effect manifests itself only after all the prothrombin available in blood has been utilized; *so the amount of the dose given does not speed the effect on the coagulation.* The dose of Dicumerol generally used to initiate therapy is about the same throughout the country. It requires from 48 to 96 hours to produce maximal effect. Additional daily doses are given only when the prothrombin concentration rises above 25 per cent of normal. Most workers attempt to maintain the level of prothrombin activity at between 25 per cent and 15 per cent of normal. We prefer regulating our anticoagulant therapy on the basis of acutal seconds for the prothrombin time, optimum time of two and a half times the control being sought in the average case.

It is reported that liver damage enhances the activity of anticoagulant given. It is even suggested that Dicumerol or anticoagulants be used as tests of liver function. Kidney malfunction may also enhance the effect of Dicumerol.[16]

In a recent meeting of the International College of Physicians[17] he panel on anticoagulant therapy was polled on various questions relating to the anticoagulant drugs. Among questions asked was this: When should one cease long term anticoagulant treatment? The consensus was that it is still not known how long such therapy can be maintained. It may be reduced or stopped temporarily for minor or major surgery, but most benefits seem to occur in the first two years. It is accepted generally as most valuable in the treatment of patients with recurrent myocardial infarction. Since recanalization of a coronary occlusion takes at least six months for completion, most of the panelists agreed that anticoagulant therapy should be maintained for at least one, and better, two years.

We keep our patients with postmyocardial infarction on anticoagulants indefinitely. In rheumatic heart disease with fibrillation most workers would recommend maintaining the anticoagulant treatment permanently. In thrombophlebitis, after six months, one might try stopping the treatment. The Russians, at the present time, state they use anticoagulant therapy not just in severe cases but in all cases of myocardial infarction. They attempt to increase the prothrombin time from two to two and a half times the normal. They asked whether or not anticoagu-

lants are doing more than just preventing coagulation. Though there are many new anticoagulants, the variation is in their potency, rate of metabolism, and destruction.

Many felt that much improvement is needed in our present handling of thromboses. For example, Dr. Astrup of Denmark thought that fibrinolysin, as now available, should be used along with the anticoagulants to remove the thrombus since the anticoagulant can not. The anticoagulant can only prevent it. Dr. Astrup thought that the present control of anticoagulant drugs was not as good as it should be; we need better factors to test than the prothrombin time alone. He suggested the use of the Stewart factor. With oral vitamin K-1 we can control elevation of prothrombin times above the safe range and not bring prothrombin down to too low a level to interfere with anticoagulant therapy. Most serious hemorrhagic accidents occur when the prothrombin time is elevated over 35 seconds. Very few undesirable side reactions with anticoagulants were reported. There are only occasional allergic reactions, most to the Phenylindanediones, and no reported allergic responses to the Coumarol group. Any liver damage would simply make the patient more sensitive to the anticoagulant. However, there is no evidence that the anticoagulants produce such liver damage. Further, it is noted that the anticoagulants are much more sensitive in acute congestive heart disease. This may be the result of depressed liver function, as in our last two cases here. The patients undoubtedly had liver damage and cardiac embarrassment.

Thromboses in a patient, in spite of continued properly handled anticoagulant therapy, must make one think of something such as a malignancy complicating the therapy.

Complete resistance to anticoagulants has proved rare, and as yet, after over twelve years of anticoagulant use, no case is reported.

It is strongly suggested that all patients on anticoagulant therapy carry a card indicating that they are taking such medication, and that all patients be told to take the medicine at the same time each evening so that tests made at the same time in the morning would be comparable in timing, absorption, and the effect of the drug. In our last case, such a card carried on the patient's person might have helped in an earlier diagnosis.

Summary

Various types of patients on anticoagulant therapy are presented. Of 32 patients, 11 developed some complication. Two fatalities occurred. One of them was a patient on unsupervised anticoagulant therapy. He presented himself with marked hemorrhagic findings throughout the body. It was felt that proper control of his anticoagulant treatment before hospitalization, and after his hospitalization, more vigorous treatment with transfused blood and vitamin K, might have prolonged his life.

REFERENCES

1. Wright, I. S.: Present Status of Anticoagulant Therapy in Treament of Myocardial Infection. Use and Misuse of Anticoagulants; Evaluation of New Anticoagulants, Their Indications and Dosage, Ann. Int. Med. **43**:942, 1955.
2. Wright, I. S., Marple, C. D., and Beck, D. F.: Anticoagulant Therapy of Coronary Thrombosis with Myocardial Infarction, J.A.M.A. **138**:1074, 1948.
3. Wright, I. S., Marple, C. D., and Beck, D. F.: Myocardial Infarction: Clinical Manifestations and Treatment with Anticoagulants: Study of 1,031 Cases, Report of Committee on Anticoagulants, published for American Heart Association, New York, Grune and Stratton, Inc., 1954.
4. Tanzi, F., and Van Ness, A. L.: Long-Term Anticoagulant Therapy of the Ambulatory Patient Following Myocardial Infarction, M. Clin. North Amer. **41**:25, 1957.
5. Manchester, B.: The Value of Continuous (1 to 10 Years) Long-Term Anticoagulant Therapy, Ann. Int. Med. **47**:1202, 1957.
6. Weiss, M. M.: Ten Years Prognosis of Myocardial Infarction, Am. J. M. Sc., **231**:9, 1956.
7. Russek, H. I., and Zohman, B. L.: Selection of Patients for Anticoagulant Therapy in Acute Myocardial Infarction, Am. J. M. Sc. **228**:133, 1954.
8. Lee, K. T., and O'Neal, R. M.: Anticoagulant Therapy of Acute Myocardial Infarction: Evaluation from Autopsy Data with Special Reference to Myocardial Rupture and Thromboembolic Complications, Am. J. Med. **21**:335, 1956.
9. Bay, E. B., Adams, W. R., Jones, R. J., Page, R. C., Seide, M.: The Use of Anticoagulant Drugs in Ambulatory Patients, Circulation **9**:741, 1954.
10. Halpern, M. M., Lemberg, L., Belle, M., and Richert, H.: The Selective Use of Anticoagulants in Acute Myocardial Infarction. Based on Initial Prognosis, Ann. Int. Med. **41**:942, 1954.
11. Russek, H. I., and Zohman, B. L.: Prognosis in Uncomplicated First Attack of Acute Infarction, Am. J. M. Sc. **224**:496, 1952.
12. Russek, H. I., and Zohman, B. L.: Survey of Specialists Opinion in the Use of Anticoagulant Therapy in Acute Myocardial Infarction, Am. J. Med. Sc. **225**:8, 1953.
13. Susman, M. M., Goldberg, B., and Ruskin, H. D.: An Evaluation of the Effect of Continuous Long-Term Anticoagulant Therapy on the Prognosis of Myocardial Infarction, Circulation **12**:338, 1955.
14. Wright, I. S., and DiFrancisco, A.: Thromboembolic Complications Following So-Called "Good Risk" Cases of Myocardial Infarction, Circulation, **13**:692, 1956.
15. Link, K. P.: Anticoagulant from Spoiled Sweet Clover Hay, Harvey Lecture Series, **39**:162, 1944.
16. Goodman, L. S., and Gilman, A.: Pharmacological Basis of Therapeutics: Textbook of Pharmacology, Toxicology, and Therapeutics for Physicians and Medical Students, ed. 2, New York, The Macmillan Company, 1955.
17. Wright, I. S. et al.: Panel on Anticoagultant Therapy, Fifth Congress, International Society of Internal Medicine, Philadelphia, April 24, 1958.
18. Duff, I. F., et al.: The Control of Excessive Effect by Anticoagulants, Ann. Int. Med. **43**:955, 1955.

Executive Administrator Reports On Reorganization Plans

Robert L. Richards, *Executive Administrator*

The following article is the first in a series which will be published from time to time in The Journal describing the progress being made in the reorganization of the Society. These administrative changes are being made by the Executive Administrator with the approval of the Council and are financed through your membership dues. Every member should take an interest in the activities of the new administrative staff, and we recommend these reports to your special attention.

H. Close Hesseltine, *President*
E. A. Piszczek, *Chairman of the Council*

The chairman of the Council has asked me to comment on our administrative plans for the future. This opportunity is welcome as will be any other request to discuss the business of the Society with the House of Delegates or any county medical society.

To avoid any false impressions, permit me to say that any organization—including a state medical society—periodically should have an opportunity to re-appraise its purposes, its functions and its services to members and to the public. My information is that you initiated such a re-appraisal about a year ago. The updating of your By-Laws is now virtually complete, making possible further modernization of the mechanics of your operation. You have authorized your Council to employ the staff necessary to implement the mechanics—to grease the gears, to place wheels under the chassis, to rev up the motor and to get the vehicle rolling.

A year ago you decided that your organization had some administrative ailments. At that time you diagnosed the case. Now you are ready to apply treatment. The diagnosis was not easy, the remedy has been merely outlined in general and the treatment must be amplified.

There may be some untimely, and even violent, reactions. These may delay recovery and rehabilitation of the patient. Major surgery may be indicated with much pre- and post-operative care. Some areas of activity may require further diagnosis, as they are sufficiently complicated to merit special study and consultation to determine proper treatment patterns.

It is not possible at this time for me to predict accurately the reaction of this particular body politic and its various systems. However, the enlightened and progressive attitudes of your officers and Council are impressive. At the conclusion of this meeting it will be possible for me to comment on the actions of the House of Delegates, which will have so much to do with the future of the organization. Undoubtedly, the actions of the House will be as appropriate and progressive as the actions reflected in the meetings of your Council.

In speaking of future staff services, it should be perfectly clear that my comments place not the slightest reflection on past management or staff. Even a superficial analysis indicates that the continued loyalty and devotion of your present staff have reduced substantially the rehabilitative measures which might well have been considerably more drastic. I am also very much aware of the love and affection in which Dr. Camp was held by this House of Delegates. Your committee reports reveal some remarkable ac-

Presented before the House of Delegates of the Illinois State Medical Society on May 23 and 26 during the 1960 annual meeting.

tivities which, when better organized, should provide adequate programs for the immediate future.

When the present staff is augmented, reorganized and assigned responsibilities with commensurate authority, it should meet present needs. This expansion and reorganization should permit further development of positive programs which organized medicine sorely needs in these days of socialistic encroachments upon medical practice and the care of your patients.

As most of you know, some months have passed since negotiations were concluded, making me your executive administrator. It will not be possible for me to report for full time duty until June 20, but not all of this intervening time has been wasted. Conferences with your Council and interviews with prospective employees have produced concrete results. Additional time has been devoted to contacts with other state medical society executives involving lengthy discussions on how they are meeting their administrative needs and, incidentally, how those needs are being financed .

My close association with the Pennsylvania Medical Society for twelve years, and eighteen months service as executive director of a rapidly growing national specialty group, have provided me with experience which should prove valuable in approaching your staff and organizational problems.

Tentative staff plan

After a thorough study of your management survey and many consultations with executives facing similar problems, I have devised a tentative chart of staff organization which has been given your Council. This chart outlines areas of responsibility and authority for administrative purposes.

(See chart on page 100.)

Your Council has authorized me to secure the best qualified men available as directors of services in five basic areas, which in my opinion, must be covered in a successful medical society. These areas are:

1. Legislative Services and Regional Office Facilities
2. Public Relations and Field Services
3. Medical Services and Economic Research
4. Publications and Scientific Activities
5. Business and Office Management Services

In reviewing personnel requirements, the present staff was quite naturally the starting point and priority was given them in all planning. Perhaps the best known person on your staff after many years of service is Mrs. Frances Zimmer. Her ability and experience will continue to serve you well. She has been asked to serve as my Executive Assistant and Business Manager. In this capacity she will serve as office manager of the Chicago headquarters, with the responsibility of employing and supervising the personnel necessary to perform routine office functions.

She will also coordinate all office services for the four directors, purchase supplies and equipment and supervise the bookkeeping and financial records. She will also serve as my aide in preparing for meetings of the Council and the House of Delegates. You all know her but I would like Mrs. Zimmer to rise and be recognized.

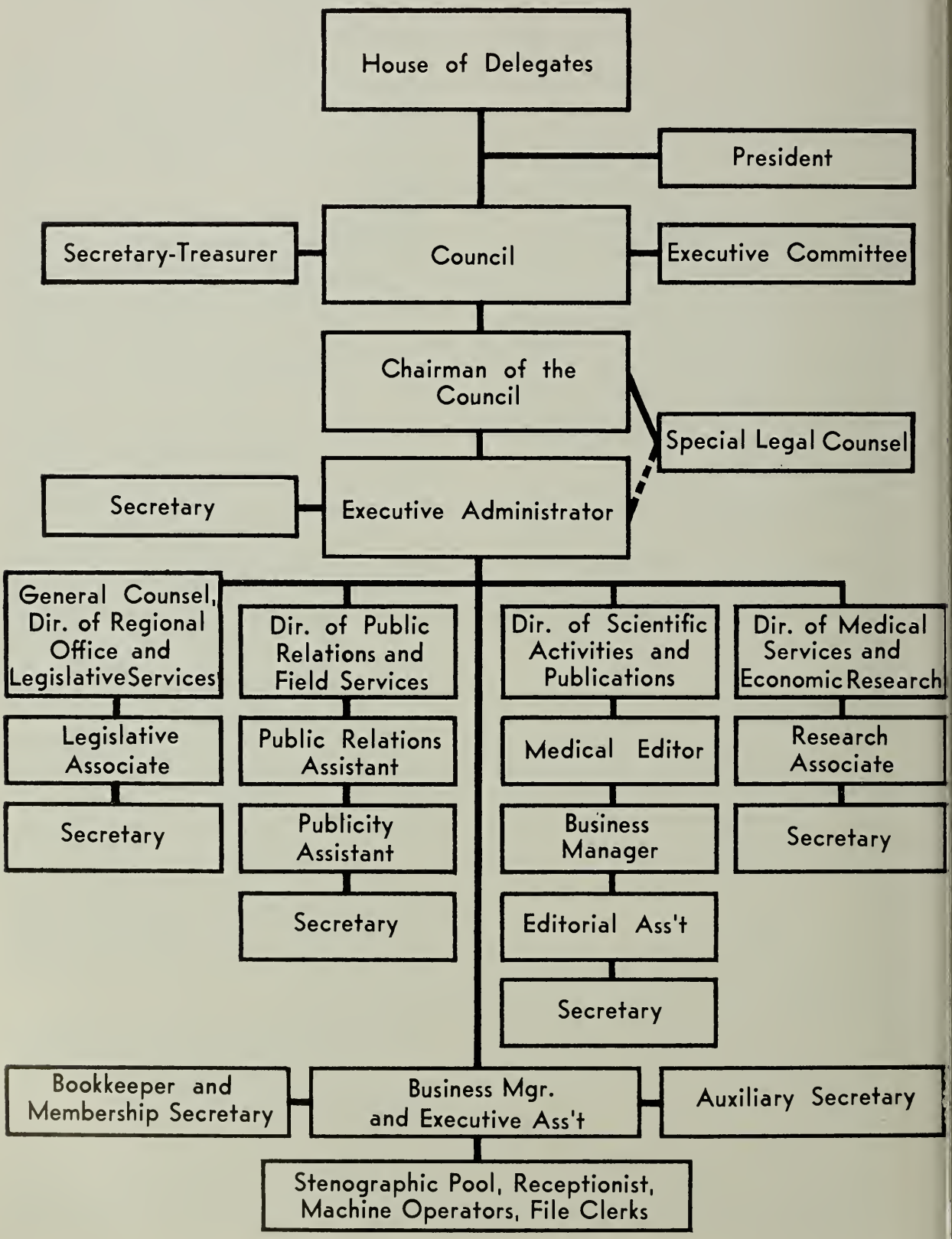
The Society's legislative program cannot be overemphasized. You are familiar with the capabilities of your present Associate General Legal Counsel and Legislative Representative, Mr. Walter Oblinger. He has consented to continue in this capacity and will be given the further responsibility of establishing the Regional Office in Springfield to serve the downstate counties. We all have perfect confidence in Mr. Oblinger's ability to provide satisfactory services to the downstate societies and to improve an already excellent legislative program.

Provision for staff in the Regional Office and a general service program will be worked out, consistent with the desires of the Council, after consultation with those of you from Downstate who are more interested and concerned. Undoubtedly Mr. Oblinger has plans and ideas which he will communicate to me at his earliest opportunity. Most of you also know Mr. Oblinger but I would like him to rise and be recognized.

Major service areas

Your independent professional management study included recommendations for the employment of an Assistant Executive Administrator, a Director of Public Relations and a Director of Field Services. There are two other areas of immediate importance and broad significance which must be combined with these to preclude large gaps in our administrative services. These

PROJECTED CHART OF STAFF ORGANIZATION
ILLINOIS STATE MEDICAL SOCIETY
As of May, 1960



additional areas are (1) scientific activities and (2) socioeconomic development and research activities.

To have adequate staff direction but not lose administrative control, my recommendations to the Council provided that the three positions described by the management study be changed in name and character so that three staff members could cover the *five* fundamental areas.

It was my further desire that there be no Assistant Administrator per se, but that Mrs. Zimmer serve as my executive assistant. This will automatically permit staff directors complete freedom to report directly to me rather than through an assistant and allow me to work closely with the directors in the development of their respective programs.

Further, it has been my experience that field services in a state medical society cannot be rendered properly as a separate function. They can be performed best by those supervising the basic services in those areas which are being discussed in the field.

For example, the best man to discuss legislation is Mr. Oblinger. He should conduct the principal field service program in legislative activity and any substitute would obviously be less satisfactory at meetings of county medical societies. This does point up, however, the necessity for close coordination of all field services. This coordination can best be handled by the Director of Public Relations, although he is not necessarily the only person to whom this responsibility could be entrusted.

Public relations and field services combined

It is my decision that the Director of Public Relations shall coordinate all field services and develop them to the point where they are eminently satisfactory to the officers of the county medical societies.

The man chosen for this position as Director of Public Relations and Field Services is Mr. Donald Martin, presently Director of Public Relations for the Illinois State Bar Association, and undoubtedly known to many of you. He reports for duty July 1.

Mr. Martin comes to us with an excellent reputation and ample evidence that he has what it takes to put wheels under a public relations program for this society. I should like to introduce Mr. Donald Martin.

One of the best means of communicating with our members is through the pages of our medical journal. Other publications such as newsletters, announcements of post-graduate courses, etc., must be managed by a staff member. As most of these publications will be replete with information about the scientific activities of the Society, it was necessary to find a man with both publications and scientific educational background.

Fortunately such a man was found. He also has had excellent public relations experience in the formation of the Medical Center at Syracuse and later with Oscar Mayer & Co. Actually, he originally applied for the position of Director of Public Relations but was persuaded to accept the position of Director of Publications and Scientific Activities of your Society. On May 16, Mr. Albert G. Boeck, Jr., reported for duty and has been assisting Dr. Lull in arrangements for this meeting. I should like to introduce Mr. Albert Boeck, Jr.

The medical editorship of the Journal will be retained by Dr. Van Dellen. It is most gratifying to find that you have such an extremely well-qualified physician who has done so much toward the improvement of the Journal in his few short months as editor. His report to the House of Delegates is excellent.

Need for economic research

More than ever, the pressures are on today for financing medical care and providing methods for fulfilling increased demands for medical services. Contracts and fee schedules are being considered almost daily.

Periodic reviews and negotiation of fee schedules for Blue Shield, Medicare, Federal Employees Health Insurance programs and others are becoming standard activities of some of your committees rather than unusual occurrences as they were ten years ago.

It is my understanding that someone on the staff of the State Society must soon develop a Relative Value Study as directed by the House of Delegates and the Council. Someone must develop plans and services which will enhance the position of the profession rather than place it in jeopardy. Someone must be capable of analyzing medical care problems and suggesting solutions to suit the varying needs of different sections of the state. He must be thoroughly acquainted

with hospital, nursing and related needs which seriously affect the corporate image of organized medicine. He must have a background in organized medicine, yet not allow a too-sympathetic attitude cloud his objectivity when analyzing socioeconomic problems and formulating their solutions.

More than anything else, medicine must provide some of the diagnoses, treatment and follow-up care on the patient politic. Someone must provide the ammunition for those in the profession who must pull the trigger that fires the bullet. Or, in more modern terms, trigger the mechanism which will fire a barrage of missiles at those currently advocating socialization of all medical sciences.

This same person would be required to follow substantially the requests of the AMA Council on Medical Services which has become so active in recent years. The requirements of this subject could be discussed at length should this Society decide to implement the many recommendations of that Council.

We are fortunate in finding a uniquely qualified person to meet the many exacting specifications of this job. He is Mr. Roger N. White, a former co-worker of mine at the Pennsylvania State Medical Society, who is currently Executive Director of the Lackawanna County Hospital Council. He has been dealing with the practical problems of providing coordinated medical care programs in a large area of northeastern Pennsylvania. I should like to introduce Mr. Roger White, Director of Medical Services and Economic Research.

This is a preliminary administrative report to which might be added some observations.

Professional standing of directors

You are all professionally qualified physicians. It is recognized in the profession that specialization in certain fields can be accomplished only after several years of intense study and experience. Thus it is in the field of medical administration, public relations, legislation, publications and economics.

The department heads whose employment has been authorized by your Council are sufficiently educated and experienced to be considered professionals in their particular fields. They are commended to you as my associates in the work of this Society. They require no pampering, no tender loving care. They have graduated from the school of hard knocks. They do deserve—and it is requested that you grant them—your cooperation for the future benefit of the Illinois State Medical Society.

Gentlemen, we are just now launching an ambitious reorganization program with many complex ramifications. Even with the most capable staff we can not expect overnight miracles. Much must be done before effective programs can be outlined, developed in detail, presented to and approved by committees, and then submitted to your Council for fiscal support and eventual implementation.

We offer no excuses and no alibis when we say we hope our over-all program can reach the implementation stage by this time next year. This time factor is not unanticipated by us—or by your Council — and should be understood by those of you who will stand in judgment at the 1961 meeting of this House of Delegates.

Program to consider local needs

In the meantime, you have much to offer us in the form of your particular problems. This can be achieved through meetings with your county societies, surveys instituted on special subjects, field visits and conferences with your officers. Your wishes and the services you desire will be considered and will form the basis for the programs the full-time staff must develop.

One note of caution must be advanced at this time. Programs and services cost money. A meaningful measure may be your own estimation of the expense necessary in obtaining the department heads introduced here today. Compared with other state medical societies of similar size, your staff is modest indeed. Evidence of this has been presented to your Council and is a subject that can be discussed with any of you without embarrassment.

Although we bring you a broad administrative staff organization sufficiently diversified to attain our objectives, it is still flexible and fluid. At all times we must be able to improvise, to change and to display ingenuity in meeting rapidly differing conditions as they arise from day to day. The administrative staff is so designed.

The new staff members and I are most optimistic about the future of the Society. We ask your cooperation, your patience and your toler-

ance. To us, this is not just another job where financial returns were the sole factors in our decision to join you.

We bring you seasoned enthusiasm, complete devotion and dedication to those high principles traditional in the medical profession. If experience, enterprise, initiative and just plain hard work will solve your problems, it is my belief that you will be pleased with the efforts and results of your staff.

Meeting on May 26

The privilege was granted me at your first session to outline administrative plans for the future. At that time I indicated our plans were flexible and that dynamic administrative changes were possible under that plan. It seems proper, then, that I keep you informed of a few administrative changes which have occurred in the last two days. I therefore have asked the privilege of the floor to discuss two subjects:

First: At its meeting on May 24, the Council approved a total administrative chart. This chart should ease any apprehension on the part of any employee with respect to his future status in the administrative plan. I welcome the discussion of these positions with any delegate or any employee who may wish detailed information.

Second: I would like to comment on a change in major assignments. Mr. John W. Neal has served your Society with distinction for more than 19 years. He has been your General Counsel and has met with the Council on all matters pertaining to the development of the administrative staff.

On his own initiative he has suggested that Mr. Oblinger become the General Legal Counsel and that he, Mr. Neal, become the Society's Special Legal Counsel, subject to election by the new Council each year. This change is prompted by the fact that Mr. Neal has many other activities and will be unable to give us the time he believes necessary to meet the increased demands on the General Legal Counsel.

Therefore, because Mr. Oblinger will be a full-time employee to the Society effective July 1, 1960, it is agreed that he shall serve in the capacity of General Legal Counsel in addition to his other duties.

Neal to become special counsel

Fortunately, Mr. Neal has agreed to continue to be available at all meetings of your Council and at all sessions of this House of Delegates. He will serve the Council Chairman and the Presiding Officer of the House of Delegates as legal advisor in the formation of policies of your Society. He will also be a consultant to me and to Mr. Oblinger on special legal problems.

You are indeed fortunate to have had the services of Mr. Neal for 19 years, but we are even more fortunate in retaining his services as Special Counsel for future years. You may note that Mr. Neal is now seated in the front of the House of Delegates to better serve the Presiding Officer of this House as his legal advisor.

Laws just or unjust may govern men's actions. Tyrannies may restrain or regulate their words. The machinery of propaganda may pack their minds with falsehood and deny them truth for many generations of time. But the soul of man thus held in trance or frozen in a long night can be awakened by a spark coming from God knows where and in a moment the whole structure of lies and oppression is on trial for its life. — *Winston Churchill*

A well-ordered life is like climbing a tower; the view halfway up is better than the view from the base, and it steadily becomes finer as the horizon expands. — *William Lyon Phelps*

* *

The power in which we must have faith if we would be well, is the creative and curative power which exists in every living thing.

— *John Harvey Kellogg*

THE P. R. PAGE

Donald L. Martin, *Director of Public Relations*

Some questions are raised

Do you have the answers?

It probably won't come under the heading of news that ISMS now has a committee on Public Relations. The splitting of the former Committee on Medical Services and Public Relations into two separate groups—each with its specific area of responsibility—was amply described on this page last month. But what might interest you is the immediate program of the newly constituted P.R. Committee.

A first meeting between the new committee chairman, Dr. Robert E. Heerens of Rockford, and the writer raised a number of questions to be fully explored by the committee. Briefly, they are as follows:

1. Is there a need for improved communications between the state society and its component groups as well as between the society and its individual members?
2. In addition to opposing the force of socialization, should we not also adopt a number of sustaining public information programs, positive in approach, to tell the story of Illinois medicine?
3. Are we now doing an adequate job of attracting young men and women of character and ability to the profession of medicine, thus assuring to future generations the best in medical attention?
4. Are there legitimate areas for public service that are being neglected or overlooked? Have we been sufficiently concerned with community problems and governmental affairs?
5. Have we made an adequate effort to cooperate and maintain an active liaison with other professions, with the press, with educators and legislators?
6. Have we taken the initiative in seeking solutions to the problems of medicine on all fronts, or do we find ourselves primarily concerned with special areas that are more attractive than others?
7. Last, but by no means least, are we getting our message across? Have we effectively explained to the public the benefit it receives from the personal physician-patient relationship free from third party intervention?

Perhaps the answer to some of these questions is yes; to some, no. It will be the immediate task of the committee to research these questions and to supply the answers.

How you can help

During the coming months the Committee on Public Relations is expected to meet frequently in its effort to better serve you, the individual practitioner, and your county societies. What assistance or programs would you like to receive locally from the Committee on Public Relations?

Your suggestions or constructive criticisms will be gladly received and given thorough attention.

Examine the seven questions above and send your comments to the Director of Public Relations, Mr. Donald L. Martin, Illinois State Medical Society, 360 North Michigan Avenue, Chicago 1. Thank you.

EDITORIALS

Tuberculosis eradication

The first sixty years of the twentieth century have seen great advances in the control of communicable diseases. Vaccination against smallpox slowly wiped out smallpox epidemics. Chlorination of water, pasteurization of milk, improved sanitation, and refrigeration as well as collection and treatment of human sewage has almost completely eradicated typhoid fever, paratyphoid, and many of the common dysenteries. The development of good immunizing agents for use in infancy against diphtheria and whooping cough has shown the value and effectiveness of early immunization. Recent development in poliomyelitis immunization have given hope of complete elimination of paralytic poliomyelitis.

Today tuberculosis remains the last of the major communicable diseases in the first ten causes of death, but few medical men realize the progress that has been made in the control and eventual eradication of this disease. In a report of the Tuberculosis Control Committee of the Chicago Medical Society recently, it was shown that more than 1,000 private and public beds which were previously used for care and treatment of tuberculosis patients have now been turned over to general hospital use or are being used as additional beds for care of our aging population. This miraculous reduction in the number of tuberculosis hospital beds has come about by the advances of:

1. Case finding
2. Antimicrobial therapy

Case-finding methods have improved so much in the twentieth century that a very high percentage of the cases is being found in the early stage of the disease when treatment and rehabilitation can be completely effective.

Antibiotic tuberculosis therapy started with streptomycin about fifteen years ago, and along with the introduction of chemotherapy with para-aminosalicylic acid (PAS) and isoniazid (INH) in 1952, has reduced the average hospital stay from between one and a half and two years to a period of six to eight months.

The use of satisfactory antimicrobial therapy in tuberculosis has been augmented by advances in chest surgery. The trained modern chest surgeon has the benefits of an improved tracheobronchial anesthesia, has the advantages of reduced post-operative infection or spread because of the availability of many antimicrobial drugs, and has the benefits of multiple blood transfusions available for chest surgery. Today, thanks to these advances, surgery is being done on a considerable percentage of the tuberculosis cases, not only to shorten the hospital stay but to give the patients the benefit of having major tuberculosis lesions removed to reduce likelihood of a relapse.

The laboratory has become a more important weapon for recognition and effective treatment of the disease. The patient with tuberculosis is no longer kept on routine drugs without testing their efficiency against the patient's organisms. Many cases of bacterial resistance are thus discovered. Frequently some of the routinely used drugs have to be replaced in favor of others such as viomycin, pyrazinamide, cycloserine.

It is becoming increasingly evident that *"excellence* of medical, laboratory, and surgical care" is paramount in this battle for eradication of tuberculosis. Few small sanatoria can economically provide good medical care with a trained physician in chest disease, a laboratory that can provide the total analyses necessary, a blood bank, an anesthesiologist, and a surgeon who is available when needed. Those small institutions that do not provide such essentials or cannot make them readily available to their patients could be utilized to much better advantage for the care and treatment of geriatric patients for whom scientific requirements are not so high.

E. A. Piszczek, M.D., M.P.H.

TB controlled; new use urged for hospitals

In 1900 tuberculosis was the leading cause of death in the United States. The annual TB death rate was 195 for every 100,000 persons. Now the disease is under control and its eventual eradication—the present goal of medical science—seems assured.

Already more than 1,000 public and private hospital beds formerly used for TB patients in the Chicago area have been converted to other uses. Dr. E. A. Piszczek field director of the Suburban Cook County Tuberculosis Sanitarium District, contends that more than 500 more tuberculosis sanitarium beds in Illinois should be converted to the care and treatment of the aged, for whom there is an increasing shortage of facilities in hospitals and nursing homes.

State gathers data

Dr. Piszczek, former director of the Cook County health department, is chairman of the board of public health advisers to the state health department and chairman of the TB committee of the state medical society. His figures on the number and rate of occupancy of TB hospital beds in Illinois were obtained from Jerome V. Ray, chief of the bureau of hospitals in the state health department.

In Chicago, deaths from tuberculosis of all kinds declined from 174 per 100,000 in 1900 to nine per 100,000 in 1959, according to the Tuberculosis Institute of Chicago and Cook County. Newly reported cases in Chicago declined from 280 per 100,000 in 1910, when such records were first kept, to 101 per 100,000 in 1959. In Illinois the TB death rate declined from 47 per 100,000 in 1940 to eight per 100,000 in 1958, and newly reported cases declined in the same period from 108 to 64 per 100,000.

Dr. Piszczek . . . attributes this "miraculous" progress in the control of TB to advances in "case finding" and "antimicrobial therapy." He reports that a high percentage of cases now are found in the early stage of the disease, when treatment and rehabilitation can be completely effective.

The average hospital stay, formerly one and a half to two years, has been reduced to six to eight months, Dr. Piszczek writes, by the use of antibiotic TB therapy, beginning with streptomycin about 15 years ago, and by the introduction of chemotherapy with para-amino salicylic acid and isoniazid in 1952.

Many private as well as public tuberculosis hospitals were founded in the first quarter of the century. Winfield Hospital, at Winfield, which is a branch of Michael Reese Hospital, is the only remaining private institution for TB patients in the Chicago area, and a plan to convert it to other uses is under consideration. When that is done St. John's Sanatorium in Springfield will be the only private TB institution in Illinois.

The Old Chicago Fresh Air Hospital, founded by a group of philanthropists, now is the 100 bed Bethesda General Hospital. For many years the Fox River Sanitarium at Batavia was operated by the Jewish people's Chicago Consumptive Aid Society. Now it is operated as an old people's home by the same society.

The 150 bed Edwards Sanitarium for TB patients in Naperville has become the Naperville General Hospital. The 75 bed Zace Sanitarium in Winfield, operated for TB patients for many years, now is a retirement and nursing home. The Oak Forest Infirmary, an old people's home, once allocated 500 or 600 beds to TB patients. Now these beds are used for general geriatric care, and the institution no longer takes acute TB cases.

New uses proposed

There are 26 tuberculosis hospitals with a total of 3,541 beds in Illinois. A recent survey disclosed that 2,823, about 80 per cent, of the beds were occupied. Dr. Piszczek contends that some of the smaller institutions which have inadequate facilities and professional personnel for the care and treatment of TB patients should be converted to nursing homes for the aged.

Tuberculosis patients could be sent from the small hospitals to the state's two TB hospitals, one in Chicago and one in Mount Vernon, or to large and well equipped county TB hospitals that will not be closed, Dr. Piszczek said. Others could go to St. John's in Springfield. He said the following hospitals might well be converted to geriatric care:

Alexander County Tuberculosis Hospital, Cairo, 49 beds.

Vermillion County Tuberculosis Dispensary and Hospital, Danville, 34 beds.

Macon County Tuberculosis Sanatorium, Decatur, 75 beds.

De Kalb County Tuberculosis Sanatorium, Sycamore, 14 beds.

Oaklawn Morgan County Tuberculosis Sanatorium, Jacksonville, 40 beds.

Tazewell County Oak Knoll Sanatorium, Pekin, 40 beds.

McLean County Fairview Sanatorium, Bloomington, 48 beds

Highland Sanatorium and Convalescent Home of La Salle County, Ottawa, 49 beds.

Livingston County Sanatorium, Pontiac, 47 beds.

Adams County Tuberculosis Sanatorium, Quincy, 38 beds.

Outlook, Champaign County Tuberculosis Sanatorium, Data unavailable.

Winfield Hospital, 71 beds.

The county TB hospitals were established under state laws, but Dr. Piszczek maintains that no legislation would be required to compel their conversion to geriatric care.

By Chesly Manly, reprinted from The Chicago Tribune, May 30, 1960.

Waiting it out with philately

What do you do while sitting at night in the doctor's room waiting for a woman in labor to dilate completely? Dr. Abner I. Weisman*, a New York obstetrician, keeps his wits by fussing with a stamp collection. He believes in the adage "a watched tea-kettle never boils" and visits Australia or the Belgian Congo (via his stamps, of course) between rectal or vaginal examinations. Philately, in his opinion, helps to pass the time, especially in the wee hours of the morning when the patient is progressing at a snail's pace and the physician is tempted to "hasten things up a bit." Stamps are ideally suited for this occasion because the physician engages in his hobby while practicing good obstetrics.

His stamps bring back memories of trips abroad and historical events. The study of Mexican stamps, for example, leads him to the Mayans, the Aztecs, or Cortez and his Conquistadors. It brings back Pancho Villa, Sam Houston, the story of Zapata and the Marines in Vera Cruz after the Tampico incident.

Some obstetricians smoke big long black cigars while sitting on their buttocks. TV solves the problem for others. Many chew the fat with an intern or resident. But Weisman is not an idle smoker, objects to commercials and late shows, and believes that young men in the hospital need their sleep. We know physicians who play with their coin collections, write scientific articles, read proof, or do editorial work while conducting these obstetrical safaris. Others play solitaire or catch up on their reading. Some sleep. Perhaps the hospital of the future will be more generous with space and equip the doctors' room on the obstetrical floor with facilities for other hobbies. "I'm sorry, nurse, I can't come now. I just lost a finger in the buzz saw."

*Weisman, Abner I.: Philately as an Aid to Obstetricians, The Aesculapian, 50:9 (May) 1960.

Socialized medicine in Sweden

The Scandinavian countries usually are regarded as having the most efficient socialized medical program. Sweden is to spend the equivalent of $50,000,000 to bring within the reach of all inhabitants special care for patients with heart disease, cancer, nervous disorders, and other ailments. By increasing their facilities and adding 250 physicians and 500 nurses, there will be no waiting and no need to travel far in order to get the best possible treatment.

Sweden has had compulsory health insurance since 1955. The people receive free care in a hospital ward, substantial refunds on private doctors' bills and prescriptions, payment of daily sickness benefits, and free maternity care. They have free choice of physicians, and according to release No. 799 from The American-Swedish News Exchange, private practitioners may charge any fee they wish. They are reimbursed by the sickness funds according to certain standard rates.

It is not as free as it sounds. One-half the cost is covered by individual premium payments, one-fourth by the employers, and one-fourth by the government—that is, the taxpayer. The annual premium for a person living in Stockholm is approximately $8, and another $6 is paid for the basic sickness cash benefits. Children are covered at no extra cost.

Sweden has fewer physicians and surgeons in relation to the population than the United States, but no other country has so many nurses and auxiliary hospital personnel. The number of hospital beds is higher than in most industrial nations.

AT THE EDITOR'S DESK



Potomac Poison

The Delaney Amendment (cancer clause) to the Food Additives Act of 1958 has created major problems for many industries. It imposes a flat prohibition on the use of any substance which can be made to produce cancer when ingested by animals, even if the dosage is a million times that for intended use in man or if experimental conditions are totally unrelated to actual use.

The agronomist may suffer the most because chemicals have had a dramatic impact upon our agricultural economy. Apropo of this is a 1956 report by the Food Protection Board of the National Academy of Sciences-National Research Council:

> "No one knows exactly what would happen if the use of pesticidal chemicals on the farm should be abandoned, but it is safe to say that we could not commercially produce apples, peaches, potatoes, citrus, and tomatoes, to mention only a few crops; and yields of others would be drastically reduced."

Pharmaceuticals

The Nordson Pharmaceutical Laboratories hope that every physician will prescribe phenimino-oxazolidinone for the 450 out of every 1,000 patients who come to his office complaining of weariness, lassitude, and lethargy. These are interesting statistics, but we hope Nordson takes etiology into consideration when suggesting a remedy for these common complaints.

Eli Lilly is experimenting with a duck-embryo vaccine for rabies. It has been used in over 250 subjects and does not contain the paralysis-producing myelin that causes encephalomyelitis. In addition, the vaccine contains killed viruses to avoid the possibility of causing rabies in man. Seventy-four per cent of those receiving the vaccine develop significant levels of rabies antibodies within 10 days. A report on this vaccine appeared in the May 28 issue of the J.A.M.A.

Surgical Dividends

The Deafness Research Foundation has developed a bank with a different twist. They are trying to build up a temporal bone bank to provide the otologist with anatomical material on which to learn middle ear surgery. This is a sensible idea considering how difficult it must be to teach a microscopic surgical procedure to a neophyte. This brings a new connotation to the expression "Lend me your ear."

Foreign Physicians in Training

The American Medical Association and the American Hospital Association will lower the boom on hospitals employing graduates of foreign medical schools who have not been certified by the Educational Council for Foreign Medical Graduates. There are a tremendous number of graduates coming to the United States for advanced medical training. In addition, it is difficult to obtain adequate and current information about foreign medical schools. As a result, several organizations formed a council to evaluate the qualification of graduates of foreign medical schools who seek internships, residencies, or positions as house physicians in U.S. hospitals. Certification applies only to those men and women who give direct care to the patients. It is aimed at safeguarding the health care of the American public. To pass, they must (1) possess a full and unrestricted state license to practice, in the final six months of training; (2) possess full or temporary certification from the Education Council or (3) have been given a six-month

appointment contingent on passing the Sept. 21, 1960, examination by the Educational Council.

This year there are 9,457 foreign physicians training in our hospitals, according to the Institute of International Education. This represents an increase of 13 per cent over the previous year. Physicians from the Far East led the foreign medical delegation with 38.5% of the total followed by 19.4% from Latin America, 18.1% from the Near and Middle East. There were 16.3 % from Europe. The Philippines with 2,319 was the largest single source.

The new ruling will have a definite effect on foreign physicians in the future.

Deaths from Football

The American Football Coaches Association reported that there were 108 deaths from football during the five year period 1955-59. Eighty-one sustained the injury from tackling or blocking while actively engaged in playing. There were 51 high school players in this group. Several deaths occurred among sand-lot players and at least one a year among professionals, excepting those in the National Football League. They had no fatalities during this time.

The remaining 27 deaths were caused by factors not related to body contact, such as heat stroke and heart failure.

The high number of deaths among high school athletes demonstrated again the need for stricter supervision, good equipment, instruction, preseason examinations, and prompt medical attention to injuries.

Love Finds a Way

A million and a half couples were married last year representing an increase of 2.7 per cent over the number in 1958. Mississippi had a decided drop in numbers from 36,400 in 1958 (62,500 in 1957) to 20,400 last year. The reason: The age for marriage was raised July, 1958. Memphis and Mobile, near the Mississippi border, did a thriving business with gains of 61 and 40 per cent respectively.

Pregnancy and Gallstones

Alfred M. Large and his associates from Detroit asperated the bile from the gallbladder of 28 pregnant women during Cesarean section. It was compared with the bile of 10 normal women and found to be essentially the same. They concluded that pregnancy did not alter the constituents of gallbladder bile nor change the function of the gallbladder sufficiently to cause gallstones.

Am. J. Med. Sciences. 239:713, (*June*) 1960.

Vacations without Vaccinations

Hereafter travelers arriving in the United States from Jamaica will not require a smallpox vaccination. The Public Health Service has made it a policy to remove quarantine restrictions whenever this can be done without weakening essential safeguards against bringing in a communicable disease. Other quarantine-exempt areas are Canada, Iceland, Greenland, the Canal Zone, the West Coast of Lower California as well as the Bahamas, Bermudas, British Virgin Island, Cuba, Aruba and Curacao, St. Pierre and Miquelon.

Results of Rehabilitation

The current Rehabilitation Record contains a special section on the activities and growth of rehabilitation in this country. The most surprising is the statement that 523 physically handicapped persons were restored to employment in 1920 but more than 80,000 in 1959.

Medical Care for the Aged

A partial answer to what kind of medical care is needed by our older citizens may be found in a recent study of active, retired, and permanently disabled personnel covered by the Metropolitan Life Insurance Company's group insurance program.

More older people were hospitalized for nonsurgical than for surgical conditions. The annual admission rate for men was 87 per 1,000 at age 60-64, and it increased to 80 per 1,000 at age 75 and over. For women the rate increased from 28 to 57 per 1,000 in the same age groups. Correspondingly, the length of hospitalization rose from 13 to 29 days for men, and from 17.7 to 35 days for women. Heart disease outranked every other type of nonsurgical condition as a cause of hospitalization at ages 60 and over.

Among men 60-64 the annual incidence of hospitalization for surgery was 70 per 1,000, and it rose to 80 per 1,000 at ages 75 and over; the length of hospitalization, from 14 to 19 days. For women in corresponding age groups, the

hospitalization rate increased from 45 to 57 per 1,000. The average length of hospital stay was 15.4 days but increased to 41 days for those 75 and over. Abdominal surgery ranked first among both men and women as a condition requiring hospitalization at age 60-74, but at age 75, urologic operations ranked first among men and reduction of fractures—mainly of the hip and pelvis—ranked first among women.

Just Briefly

The Monthly Bulletin of Di Cyan & Brown made the suggestion that scientific articles begin on the right-side page of a journal and end on the next or left-side page. In this way readers wishing to clip and file the article could do so without including two contiguous articles. It is an excellent idea providing our contributors confine their remarks to two or four pages.

Monkey to Mosquito to Man

Can humans develop monkey malaria? This research project is getting considerable backing from global scientists because it may change the course of malaria eradication in many parts of the world.

Monkey malaria has been transmitted to man under laboratory conditions. Volunteers develop typical symptoms of malaria; but it is a low grade infection, and it is not always possible to demonstrate the parasites in the blood. More research is needed to determine whether transmission occurs in nature and whether a reservoir of human infection exists in malaria infested jungles.

Tobacco and Heart Disease

The American Heart Association has issued a new report on the relationship of smoking to heart disease. Death rates from coronary heart disease in middle-aged men were found to be from 50 to 150 per cent higher among heavy cigarette smokers than among those who do not smoke. They emphasize that "this statistical association does not prove that heavy cigarette smoking causes coronary heart disease." On the other hand, the statistical relationship should be noted by all physicians and used accordingly when addressing patients.

Helping Hand for the Paralytic

A grant from the Easter Seal Research Foundation has helped in the development of an ingenious device that brings life to paralyzed extremities. It was built by Arthur J. Heather, M.D., medical director of the department of physical medicine and rehabilitation of the Eugene du Pont Memorial Hospital, Wilmington, Del. It weighs six ounces and is hydraulically operated by tap water. The artificial hand is described by the inventor as "a three jaw chuck type grasp with the activating mechanism placed either on the arm of a chair or in any position to enable [the user] to open the hand." This mechanical hand should help those paralyzed by accident, stroke, or polio to do many of the ordinary tasks of living such as eating, using a telephone, writing, or shaving.

Powerful Synthetics

Dr. J. J. Beereboom of Pfizer has developed a series of experimental synthetic tetracycline drugs. Some of these are four times as active as the present tetracycline against certain bacteria. In conducting the studies these compounds are pitted against the *Klebsiella pneumoniae, a* commonly used test organism.

Insuring Insurance

The Health Insurance Council reports that more than 127 million Americans had health insurance at the end of 1959. This represents an increase of 4.8 million over the year before.

The extension will continue so long as we have prosperity and the plan is not exploited. Your editor recalls that voluntary health plans were quickly absorbed by the governments of certain European countries at the first sign of financial strain during the depression.

We do not know, in most cases, how far social failure and success are due to heredity, and how far to environment. But environment is the easier of the two to improve. — *J.B.S. Haldane*

ANNOUNCEMENTS

Chicago Medical Society PG courses

Two postgraduate courses designed for both the general practitioner and the specialist, one in Modern Diagnostics and the other in Modern Therapeutics, will be given by the Chicago Medical Society in October at the Knickerbocker Hotel, Chicago. The courses, intensive reviews, have been scheduled for two consecutive weeks so that those who wish may take both. Modern Diagnostics will be covered from October 17 through 21; Modern Therapeutics, from October 24 through 28. The registration fee for each is $75 and includes luncheon tickets, morning and afternoon refreshments, and a booklet containing a summary of all lectures.

Most of the 43 faculty members for each course are from the medical centers of Chicago, are authorities in their fields, and are known for their teaching abilities. Out-of-town faculty include: Drs. Bruce J. Brewer, Milwaukee; Paul A. di Sant'Agnese, National Institute of Arthritis and Metabolic Diseases, Pediatrics Branch; David Karnofsky, Memorial Center of Cancer and Allied Diseases, New York; Armand J. Quick, Marquette University; Sheldon C. Reed, University of Minnesota; and Harold Rosen, John Hopkins University.

The subjects of the Modern Diagnostics course are as follows: Monday, pediatrics; and in half-day sessions, Tuesday, dermatology and otorhinolaryngology, and ophthalmology; Wednesday, vascular disease and orthopedics; Thursday, genitourinary diagnoses and gynecology; Friday morning, laboratory procedures.

For the course in Modern Therapeutics, half-day periods are set as follows: Monday, neurology and psychiatry; Tuesday, hematology—coagulation disorders and anemias; Wednesday, cardiology—medical and surgical; Thursday, infectious disease and newer concepts in genetics; and Friday morning, endocrinology.

Early registration is urged, since registration is limited. Checks may be made out to the Chicago Medical Society and sent to the Committee on Postgraduate Education, Chicago Medical Society, 86 East Randolph Street, Chicago.

Rehabilitation courses at NU

A series of classes for directors of rehabilitation centers and coordinators of rehabilitation services, with emphasis upon integration of medical, administrative, and vocational functions, is being sponsored by Northwestern University from September 6-16 in Wieboldt Hall on the university's Chicago campus. Co-directors will be Dr. Bernard J. Michela, director of the Rehabilitation Institute of the medical school, and Dan Macer, manager of the Veterans Administration Research Hospital, also part of the medical center. The tuition fee is $50. Applications should be sent to Miss L. G. Jackson, Hospital Administration, 339 E. Chicago Ave., Chicago 11.

September clinics for crippled children

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. There will be nineteen general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examinations along with medical, social, and nursing service, two special clinics for children with cardiac conditions, two for children with cerebral palsy, and one for children with rheumatic fever.

September 2	Chicago Heights (Cardiac), St. James Hospital
September 7	Carmi, Carmi Township Hospital
September 7	Hinsdale, Hinsdale Sanitarium
September 7	Rock Island (Cerebral Palsy), Foss Home

September 8	Effingham, St. Anthony Hospital
September 8	Springfield, St. John's Hospital
September 8	Sterling, Community General Hospital
September 13	East St. Louis, St. Mary's Hospital
September 13	Peoria, Children's Hospital
September 14	Champaign-Urbana, McKinley Hospital
September 14	Jacksonville, Our Saviour's Hospital
September 14	Joliet, Silver Cross Hospital
September 15	Anna, County Hospital District
September 15	Rockford, Rockford Memorial Hospital
September 20	Alton, Alton Memorial Hospital
September 21	Evergreen Park, Little Company of Mary Hospital
September 22	Decatur, Decatur-Macon County Hospital
September 22	Elmhurst (Cardiac), Memorial Hospital of DuPage County
September 22	Sparta, Sparta Community Hospital
September 27	Effingham (Rheumatic Fever), St. Anthony Hospital
September 27	Peoria, Children's Hospital
September 28	Aurora, Copley Memorial Hospital
September 28	Centralia, St. Mary's Hospital
September 28	Springfield (Cerebral Palsy), Memorial Hospital

Survey use of obstetrical wards for gynecological care

The American College of Obstetricians and Gynecologists with six other national medical organizations will make a survey to determine the advisability and feasibility of using a portion of the obstetrical facilities in large cities for the care of gynecological patients.

Greater use of the maternity facilities of new hospitals and additions in suburban areas has left the maternity sections of some large urban hospitals only 50 to 60 per cent occupied. The purpose of the survey is to relieve the shortage of beds in other hospital sections.

Cooperating with ACOG will be the American Academy of General Practice, American Academy of Pediatrics, American Hospital Association, the Children's Bureau of the Department of Health, Education, and Welfare, and the maternal health, nursing, and statistics sections of the U.S. Public Health Service. The project is made possible by a grant from the National Institutes of Health.

A qualified epidemologist will be selected to initiate the program and to direct the study on a full time basis.

World congress on welfare of cripples

The International Society for the Welfare of Cripples will hold its 8th World Congress August 28 through September 2 at the Waldorf-Astoria Hotel in New York. More than fifty rehabilitation installations and facilities in the New York area will show programs and demonstrate their work. In addition to four days of scientific and professional presentations, new rehabilitation techniques will be displayed in scientific exhibits, including one on rehabilitation appliances prepared by the American Board for Certification in Orthopedics and Prosthetics.

International conference on nutrition

The Fifth International Congress on Nutrition will meet in Washington, D.C., September 1-7, with headquarters at the Sheraton Park and Shoreham hotels. An all-day symposium on "World Food Needs and Food Resources" will be one of the main features of the scientific program. Seven, half-day panel sessions and special 10-minute papers reporting unpublished original research will be presented.

National Cancer Conference

The American Cancer Society and the National Cancer Institute have joined at four-year intervals to bring together the nation's cancer workers to assess and appraise progress being made. This meeting, The National Cancer Conference, is being held this year in Minneapolis at the University of Minnesota, September 13-15. The theme of this year's program is "Changing Concepts Concerning Cancer." "Frontiers in Biology and Cancer Research" will be discussed on September 14, and "Care of the Advanced Cancer Patient" on September 15. In addition to hotel accommodations in downtown Minneapolis, low-cost university dormitory and food

facilities will be available. Registration in advance of the meeting may be made to the American Cancer Society, Inc., Medical Affairs Department, 521 West 57th St., New York 19.

Round-the-world tour

The International College of Surgeons' annual round-the-world clinical tour will take off from New York September 18 for 55 days of surgical sightseeing and be back for Thanksgiving.

The itinerary includes Paris, Athens, Beirut, Jerusalem, Cairo, Bombay, Delhi, Bangkok, Manila, Hong Kong, Nagoya, Tokyo, Honolulu, and San Francisco. The travelers, under the leadership of Dr. Walter F. James, newly appointed executive director of the college, will observe and discuss surgery in these cities as well as hold joint meetings with foreign chapters of the college. There were 35 surgeons on the 1959 tour.

Defense council conference

The Medical-Health Section of the U.S. Civil Defense Council will meet in Minneapolis September 21-22 at the Leamington Hotel. Papers to be presented include chemical and biological warfare threats and defense and emergency health programs. Physicians as well as health officers are invited to attend.

Industrial health congress in October

The Congress on Industrial Health, sponsored by the American Medical Association's Council on Occupational Health, will convene October 10-12 in Charlotte, N.C. The program is directed primarily to the general practitioner who, it is estimated, handles close to 90 per cent of all occupational medical practice. Topics to be discussed include occupational health in agriculture, mental and emotional health in industry, and dermatitis.

ACS clinical congress in October

The Clinical Congress of the American College of Surgeons will be held at the Civic Auditorium in San Francisco October 10 through 14. The program includes nine postgraduate courses, surgical forums demonstrating laboratory research in leading medical centers, and panel sessions. Wendell M. Stanley, director of the virus laboratory at the University of California, Berkeley, and Nobel winner in chemistry, will deliver the Martin Memorial Lecture on virus-cancer relationships. Leslie Philip Le Quesne, London, England, will give the Baxter Lecture on body fluid disturbances resulting from stomach obstruction.

Memorial to journal editor

Friends and associates of Harriet Cunningham, late managing editor of the Texas State Journal of Medicine, have set up the Harriet Cunningham Memorial Graduate Fellowship in Medical Writing at the University of Texas. Miss Cunningham had been on the staff of the association since 1945.

Professional nutrition society formed

Formation of a new professional association, American Society for Clinical Nutrition, was announced during the spring meetings of the American Society for Clinical Investigation and the American Federation for Clinical Research.

Officers elected were president, Richard W. Vilter, M.D., professor of medicine and chairman of the department, University of Cincinnati College of Medicine; president elect, Dr. Robert E. Olson, professor and head of the department of biochemistry and nutrition, University of Pittsburgh, Graduate School of Public Health; secretary-treasurer, Robert E. Hodges, M.D., associate professor of medicine, University of Iowa School of Medicine.

Elected to the governing counsel were Dr. Willard A. Krehl, Marquette University School of Medicine; Dr. Robert A. Goodhart, National Vitamin Foundation, New York; W. B. Bean, M.D., professor of medicine and chairman of the department, University of Iowa School of Medicine.

A four-point list of objectives adopted at the first meeting states that the ASCN shall: (1) foster high standards for research on human nutrition; (2) promote undergraduate and graduate education in human nutrition; (3) provide a place and opportunity for research workers on problems of human nutrition to present and discuss their research activities and results; and (4) provide a journal for publication of meritorious work on human nutrition.

The new society has been incorporated under the laws of the State of New York, and will have

its headquarters at the office of the secretary-treasurer.

Membership in the ASCN is by nomination and will include physicians and other biological scientists actively engaged in research and teaching in the areas of human nutrition and metabolism.

TB society name change

The American Trudeau Society, medical section of the National Tuberculosis Association, has changed its name to the American Thoracic Society to reflect more accurately the broad interests of its membership in all diseases of the chest and respiratory tract. Organized in 1905 as the American Sanatorium Association, the section first changed its name when it was reorganized in 1939.

New health insurance for Federal employees

The largest employer in the world—the U. S. Government—began in July contributing to the cost of health protection for Federal employees and their families under two insurance programs. Illinois physicians serve some 100,000. There are two plans.

During the month of June Federal employees in Illinois, along with those throughout the country, were given the opportunity to choose between Blue Shield-Blue Cross and a commerical insurance program. They likewise have been given the opportunity to choose between two types of special Blue Shield programs, at different rates.

Under the new High Option Blue Shield Program there is a maximum surgical schedule of $300; special allowances are paid the physicians for visits in a hospital for nonsurgical cases for up to 120 days per admission. Under the Low Option Blue Shield Program there is a maximum surgical schedule of $200 with allowances toward in-hospital medical visits for up to 30 days per hospital admission.

Whenever a physician serves a Blue Shield member covered under this program, he should report the case as usual to Blue Shield, but obtain from the patient and include on his Blue Shield Physician's Report full information as to the branch of the government and the specific location at which the patient works, so that his eligibility for benefits may be checked and payment made quickly.

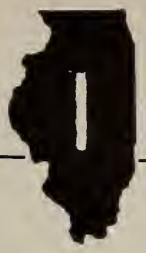
AGP and "Project Hope"

The American Academy of General Practice is urging trained family doctors to participate in "Project Hope," a plan that will send four modern hospital ships to ports of call around the world. Tours of duty would be for one year or two months. The academy has made a $1,000 contribution to the program, which is supported by voluntary contributions. The first ship is expected to sail in September.

Cerebral insufficiency

The inability of the central nervous system to withstand hypoxia for more than a few minutes will probably always limit any surgical therapy after hemiplegia has occurred. However, there appears to be developing a practical and perhaps lasting therapeutic approach to the problems of intermittent attacks of cerebral insufficiency. Prophylactic reconstruction or by-passing of thrombosed arteries appears to be a logical approach before irreversible neurologic changes take place. Certainly if this method can be developed on a wide scale, it may offer a new approach in the treatment of cerebral vascular diseases in which previous therapy has appeared futile. *Paul E. Slaton, M.D. Thrombosis of the Internal Carotid Artery: Diagnosis and Treatment. Am. Pract. & Digest Treat. March 1960.*

NEWS of the STATE



County

Champaign

The Champaign County Medical Society has taken steps to form a Medical Education Committee to act as an advisory group to students interested in following a medical career. The committee will seek approval from the University of Illinois to determine whether or not such a committee would be of assistance.

Cook

Hospital Certified. Forest Hospital in Des Plaines has been given full approval by the Central Inspection Board of the American Psychiatric Association and the Joint Commission on Accreditation of Hospitals.

The staff of the 90-bed psychiatric hospital has recently been increased to 42. New appointees are Drs. Jerome Katz and Samuel Liebman. Dr. Thaddeus Wozniak, an orthopedic surgeon, has been appointed a consultant.

Elections. Newly elected officers of the Chicago Psychoanalytic Society include Drs. Irene Josselyn, president; Gerhart Piers, president elect; Samuel D. Lipton, secretary; Philip F. D. Seitz, treasurer.

Dr. Warren H. Cole, professor and head of the department of surgery in the University of Illinois College of Medicine, has been elected president of the newly-organized Association for Colon Surgery. Dr. Cole is also currently president of the American Cancer Society and the American Surgical Society.

Dr. Milan V. Novak, associate dean of the graduate college, University of Illinois, has been elected president of the Tuberculosis Institute of Chicago and Cook County. Dr. Eugene T. McEnery was elected second vice president and Dr. Walter C. Bornemeier, treasurer.

Popular Exhibit. "The Functional Hospital" exhibit will remain on display at the Surgery Hall of Fame, International College of Surgeons for the rest of the summer. It portrays the latest in today and tomorrow's hospital, and was originally installed to celebrate Hospital Month in May.

Fifty-year Anniversary. Dr. Salvatore Damiani, Chicago, was recently a guest at a dinner in his honor. The occasion was his fiftieth anniversary as a general practitioner. He is one of 36 Chicago physicians to have been in practice a half century.

Honored. Dr. Alfred C. Ledoux, for 25 years radiologist at St. Francis Hospital, was honored at the June 14 staff meeting. On behalf of the Sisters, Sister M. Gertrudis, O.S.F., administrator, presented him a pair of high power binoculars.

Appointment. Dr. C. Phillip Miller, professor of medicine, University of Chicago, has been appointed head of a special committee to review the policies, procedures, and decisions of the Division of Antibiotics and New Drug Division of the Food and Drug Administration. The committee will function within the National Academy of Sciences-National Research Council under the presidency of Detlov W. Bronk.

Lecturer Abroad. Dr. Jack P. Cowen, Chicago, at the invitation of the Tokyo Ophthalmological Society and the Keio University, will present a paper and demonstration entitled "Pool Gonioscopy, Technique and Visualization of the Anterior Chamber of the Eye" in October, 1960.

Medical Students Win Scholarships. Two Illinois students have been awarded scholarships for research and clinical training in allergy: Spencer Koerner of the Chicago Medical School and Sidney R. Sogolow of the University of Illinois College of Medicine. Both have completed two years of medical school. They are

among 30 students given $600 quarterly scholarships this year by the Allergy Foundation of America to encourage broader knowledge and understanding of allergic diseases.

Jackson

Society Gift to Library. The Jackson County Medical Society has given a 16th century anatomy book to the Southern Illinois University library. G. G. Provart, DuQuoin, was former owner of the volume.

The purchase price of the book was presented by the Medical Society to the SIU Foundation, which administers gifts to the university.

Ralph E. McCoy, SIU director of libraries, says the volume is one of the earliest printed books on diseases of the eye and will be one of the finest examples of early printing and binding in the graphic arts collection of the library. It is a first edition of George Bartisch's "Augendienst," printed in 1583 at Dresden, Germany, by Matthes Stokel, the official printer for August, Elector of Saxony. The volume, bound in contemporary tooled leather, contains a woodcut of the House of Saxony coat of arms.

According to McCoy, the book is one of the first printing attempts to show anatomical details by illustrative overlays in which several pictures are superimposed successively on each others. Two such illustrations in the volume show parts of the brain and eye. Included in the book are 85 full-page woodcuts depicting eye operations, anatomical details, and surgical instruments of the day.



Dr. Martin Van Brown, left, Carbondale physician, joins Kenneth R. Miller, center, executive director of the Southern Illinois University Foundation, and Ralph E. McCoy, SIU director of libraries, in examining unique features of a rare book on anatomy presented to the SIU library by the Jackson County Medical Society through the foundation. Dr. Brown is a member of the society, as well as the foundation board of directors, and he is president of the SIU Alumni Association. (SIU Photo)

St. Clair

The St. Clair County Medical Society's Public Relations Committee has prepared 60,000 immunization cards for distribution to the physician and through the schools in an attempt to interest families in the medical care of their children and in their immunization records. A social agency booklet will be distributed with the immunization cards. Dr. M. Eisele heads the committee.

General

Elections. At the recent meeting of the American College of Chest Physicians, Dr. Charles K. Petter, medical director, Lake County Tuberculosis Sanatorium, Waukegan, was elected second vice-president; Dr. Albert H. Andrews of the University of Illinois College of Medicine, treasurer; and Dr. William E. Adams, University of Chicago School of Medicine, assistant treasurer.

Dr. Horace E. Turner and Francis L. Lederer, both of Chicago, have been elected secretary-general and treasurer, respectively, of the International College of Surgeons.

Radio Program. On the evening of July 27, Dr. Kenneth C. Johnston, associate professor of bronchoesophagology, University of Illinois College of Medicine, discussed "Foreign Bodies in the Air and Food Passages" over station WJJD.

This is a public service program sponsored by the Illinois State Medical Society in cooperation with the radio station.

Illinois physicians at the AMA meeting

Over 500 physicians from Illinois attended the annual meeting of the American Medical Association in Miami. Many gained recognition for their work.

Elections

Dr. H. Close Hesseltine, Chicago, ISMS president, was elected chairman of the Section on Obstetrics and Gynecology.

Dr. Harlan English of Danville was relected to the Council on Medical Education and Hospitals.

Dr. Stanley E. Huff, Evanston, was reelected representative to the Scientific Exhibit of the Section on Dermatology.

Dr. Samuel A. Levinson, Chicago, is the representative to the Scientific Exhibit of the Section on Pathology and Physiology.

Exhibit Award Winners

From among the some 300 Scientific Exhibits, "The Mechanics of the Crico-Arytenoid Joint" received the Bronze Hektoen Medal for original investigation. The exhibitors were Drs. Hans von Leden and Paul Moore of Northwestern University Medical School—Gould Foundation. They won first place at the ISMS meeting in May.

The Billings Silver medal, awarded on the basis of excellence of fact correlation and presentation went to Drs. Durand Smith, Frederick Stenn and Michael Govostis, Northwestern University Medical School; Khalid Durrani, Englewood Hospital; Milan Wasick, University of Illinois College of Medicine; and Joseph Levenson, Chicago Medical School, for the exhibit on "Proctoscopic Manikins: Teaching the Art of Proctoscopy."

Honorable Mention

Dr. Victor E. Pollak, Robert M. Kark, Robert C. Muehrcke, and Conrad L. Pirani, University of Illinois College of Medicine, for the exhibit "The Lost Art of Urinalysis."

Dr. Harold E. Himwich, Galesburg State Research Hospital, for the exhibit "Tranquilizers, Barbiturates and the Brain."

Drs. Harry A. Oberhelman, Jr., T. S. Nelsen, L. R. Dragstedt, L. R. Dragstedt II, A. N. Johnson, Jr., E. R. Singer, E. Paloyan, and H. B. Greenlee, The University of Chicago, The School of Medicine, for the exhibit "The Role of the Pancreas in Peptic Ulceration."

John A. Mirt and Clara Mai Rutherford, Illinois State Medical Society, for the exhibit "Medical Pathfinders."

Mrs. Virginia Samter, Mrs. Gloria Jones, Children's Memorial Hospital, Chicago, for their work on medical illustration in the exhibit "The Conduction System in Cardiac Surgery."

Certificates of Merit

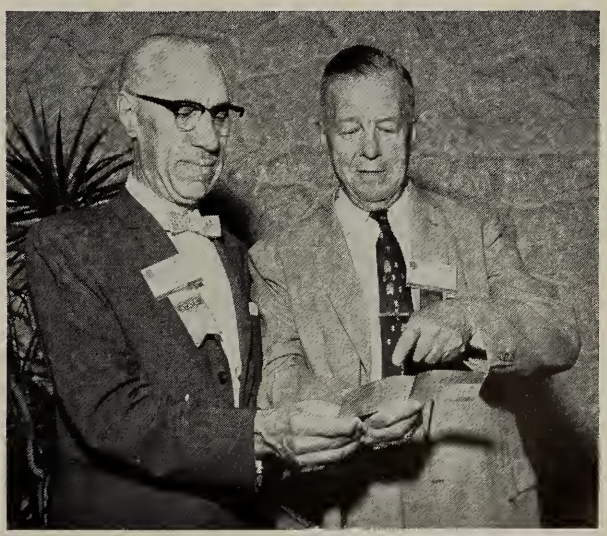
Drs. Maurice H. Cottle, Ralph H. Riggs, Roland M. Loring, and Irwin E. Gaynon, Chicago Medical School, for the exhibit "The Maxilla-Premaxilla Approach to Extensive Nasal Septum Surgery."

Drs. Maurice Lev, William L. Riker, Arthur DeBowr, Thomas G. Baffes, and Willis J. Potts, Children's Memorial Hospital, Chicago, for the exhibit "The Conduction System in Cardiac Surgery."

Drs. Gerald O. McDonald and Warren H. Cole, University of Illinois College of Medicine, for the exhibit "Stress and Decreased Resistance to Cancer."

Illinois physicians contribute to medical education

Illinois physicians, through Dr. H. Close Hesseltine, president of the Illinois State Medical Society, presented a check for $170,890 to the American Medical Education Foundation for distribution to medical schools for use as their needs may require. The presentation was made at a meeting of the American Medical Association's House of Delegates in Miami in June.



Drs. H. Close Hesseltine (left) and George F. Lull.

In handing a check for that amount to Dr. George F. Lull of Chicago, president of the foundation, Dr. Hesseltine pointed out that the Illinois physicians in the last three years had contributed an average of more than $200,000 annually, setting the national pace. Since the formation of the foundation nine years ago, their contributions through the society have exceeded $1,600,000.

The ISMS was among 20 organizations, 12 of them state medical societies, to receive the foundation's 1959 Award of Merit for outstanding

contribution to the preservation and continuance of high standards of medical education in the United States.

Dr. Lull was reelected president of the foundation.

Physicians certified

Illinois physicians recently examined and certified in the specialty of obstetrics and gynecology include Michael S. Farmans, Albert B. lon, Evanston; James F. Feeney, De Kalb; Ernst J. Plotz, William G. Slate, Lorraine J. Torkelson, Nancy C. Treadwell, and Vasil Truchly, Chicago; Milton D. Alter, Skokie; Harry W. Bergmann, Springfield; James R. Dillon, Evanston; James F. Feeney, De Kalb; Norman H. Sherman, Park Forest; George J. Shimkus, Aurora; Joseph A. Stephens, Urbana; and Francis P. Weyrens, Galesburg.

Deaths

John Aiken, Chicago, a graduate of Loyola University School of Medicine in 1917, died March 29, aged 77.

Robert L. Baird*, Chicago, a graduate of Hahnemann Medical College and Hospital, Chicago, in 1908, died March 25, aged 76. He was a Fellow of the American College of Surgeons, a member of the Industrial Medical Association, and associated with the Dixon Public Hospital.

John M. Benedetto*, Chicago, a graduate of the University of Illinois College of Medicine, Chicago, in 1926, died July 4, aged 58. He was a member of the senior surgical staffs at Columbus Hospital and Mother Cabrini Memorial Hospital, where he was a former president of the staff. He was also past president of the Society of Italian Physicians.

Ebbert Lamonte Cavenee, Champaign, a graduate of Hahnemann Medical College and Hospital, Chicago, in 1913, died March 28, aged 77.

Edwin Arthur Cohn, Chicago, a graduate of Illinois Medical College, Chicago, in 1909, died March 20, aged 83.

Kurt L. Eichelbaum*, Chicago, a graduate of Koenigsberg University, Germany, in 1925, died July 5, aged 61. He was clinical assistant professor of orthopedic surgery at the University of Illinois College of Medicine, attending orthopedic surgeon at American, Columbus, and Cuneo hospitals, and on the staff of Michael Reese Hospital. He was a Fellow of the American Orthopedic Association and the International College of Surgeons, and a member of the American Medical Association and the Chicago Medical Society.

William Thomas Ferris, Chicago, a graduate of Georgetown University School of Medicine, Washington, D.C., in 1924, died April 27, aged 60.

Marion Shelley Fink, Elmhurst, a graduate of the University of Illinois College of Medicine in 1916, died March 12, aged 72. He was on the staff of the West Suburban Hospital in Oak Park.

Frank M. Hagans*, Lincoln, a graduate of the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died June 2, aged 79.

Walter C. Hammond*, Chicago, a graduate of the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1911, died June 13, aged 72. He was a member of the staff at Ravenswood Hospital and assistant professor emeritus of obstetrics and gynecology at the University of Illinois.

Maurice L. Kochin*, Chicago, a graduate of Chicago Medical School in 1940, died June 30, aged 49. He was on the staff of the Belmont Hospital.

Edward H. Leveroos*, New Orleans, formerly of Oak Park and River Forest, and former director of the Division of Graduate Education and Hospitals of the Council on Medical Education and Hospitals of the American Medical Association, died June 19, aged 50. He was a graduate of the University of Minnesota Medical School in 1940, and since 1956 has been director of the Ochsner Foundation Hospital in New Orleans.

Ulysses Simpson Lewis*, East Dubuque, a graduate of Rush Medical College, Chicago, in 1896, died March 20, aged 93. He was on the staffs of Finley Hospital and St. Joseph Mercy Hospital in Dubuque, where he also served as mayor. For many years he had been surgeon for the Illinois Central and the Chicago, Burlington and Quincy railroads.

Samuel Jacob Lipnitzky*, Lincoln, a graduate of the University of Illinois College of Medicine in 1934, died April 13, aged 56. He

interned at the Jackson Park Hospital and served as a member of the Illinois Department of Public Welfare. A certified psychiatrist and neurologist, he was formerly associated with the Dixon State Hospital and Mansfield State Training School and Hospital in Mansfield Depot, Connecticut. At the time of his death he was on the staff of the Lincoln State School. He was a Fellow of the American Psychiatric Association, American Association on Mental Deficiency, American Medical Writers Association, and the American Association for the Advancement of Science.

John H. Luczak*, retired, Riverside, a graduate of the University of Illinois College of Medicine in 1913, died July 1, aged 68. He was on the staff of St. Mary of Nazareth Hospital.

David Holmes Morton, Elmwood, a graduate of the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1904, died April 19, aged 79. He served for many years on the grade and high school boards and was president of both boards for several years. He was also the courtesy staff of the Methodist Hospital in Peoria.

Patrick Benedict O'Connell, Gillespie, a graduate of St. Louis University School of Medicine in 1919, died March 27, aged 66. A specialist certified by the American Board of Otolaryngology, he served as examining physician on the Macoupin County Selective Service Board for many years and was associated with St. Francis Hospital in Litchfield.

Thomas J. O'Donoghue*, Chicago, Graduate of Northwestern University Medical School, Chicago, in 1911, died July 4, aged 79. He was former chief of staff at St. Joseph's Hospital.

Frank J. Pokorney*, retired, Chicago, a graduate of the University of Illinois College of Pharmacy in 1899 and the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1903, died July 1, aged 80. Beginning in 1911, he served a term on the Chicago Public Library board; in 1921 he was president of the Bohemian Medical Society; from 1923 to 1931 he served as medical examiner for the Cook County Civil Service Commission; and from 1932 to 1945 he was health commissioner of Cicero. For most of his fifty years of practice, he served on the staff of St. Anthony's Hospital.

Mannie A. Polk*, Chicago, a graduate of the University of Illinois College of Medicine in 1923, died June 24, aged 62. He was on the staff of Grant Hospital for 38 years.

F. Lee Stone*, Chicago, a graduate of the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1910, died August 1, aged 75. He was a well loved and highly respected member of the medical profession. For many years he was active in the Illinois State Medical Society and served on the Council, two years as chairman, then as president of the Society in 1956-57. He was a past president, and at the time of his death, was executive director of the Cancer Prevention Center. Dr. Stone was an associate professor emeritus of obstetrics and gynecology at the University of Illinois College of Medicine, and head of the department of obstetrics and gynecology at Henrotin Hospital, with which he had been associated for 46 years. He interned at Cook County Hospital, and during World War I served as a captain in the Army Medical Corps in France. He was a past president of the North Side Branch of the Chicago Medical Society and a member of the American Medical Association and numerous other medical and surgical societies. He was a Mason and a member of the Scottish Rite Bodies of Chicago and Medinah Shrine Temple, the Rotary Club, the Chicago Athletic Association, the Illinois Athletic Club, and Veterans of Foreign Wars.



Ernst Weichbrodt*, retired, Chicago, a graduate of the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1899, died June 24, aged 90. He was on the staff of Swedish Covenant Hospital.

Lucian Francis Wojtalewicz, Chicago, a graduate of Northwestern University Medical School in 1926, died April 2, aged 61.

**Indicates member of Illinois State Medical Society.*

BOOK REVIEWS



The Placenta and Fetal Membranes. Ed. by Claude A. Villee. $10. Pp. 404. Baltimore, Williams & Wilkins, 1960.

Study of the human placenta and fetal membranes has taken on new significance with the present plateauing of the maternal and perinatal mortality rates. This is because the human placenta occupies a key position in determining the nature of intrauterine and postnatal life. This book, which is a compilation of the available data plus a complete bibliography on this subject, is therefore a major contribution.

Part I is a condensation of our present knowledge of many different aspects of placental function presented by leaders in their respective fields, plus a complete bibliography. This should be required reading for all interested in this field, from the student for basic information to the researcher as a reference text.

A conference of these leading researchers in this field make up Part II, in which current placental research is discussed as well as the material presented in Part I. It will give the reader an idea of the experimental approaches, knowledge, and disagreements in this most important field.

To those engaged in research, Part III will be most useful, since it is a very good "attempt to provide investigators with a list of materials published since 1946, describing research on the placenta and fetal membranes."

Part IV lists a very substantial portion of the projects currently being studied by "American and foreign investigators."

The multifaceted approach to this subject employing the new investigative technics of histochemistry, radioactive isotopes, and electron microscopy will serve as a stimulus to new research and progress. The contributions of the several authors, edited by Dr. Claude Villee and the Advisory Committee, of which Dr. Louis Hellman is chairman, make a very valuable presentation for obstetricians and pediatricians, as well as those doing active research on the placenta and fetal membranes.

Albert B. Gerbie, M.D.

Emergencies in Medical Practice. Edited by C. Allan Birch. 6th edition. $8.50. Pp. 751. Edinburgh and London, E. & S. Livingstone, 1960

The survival and growth of this British book through six editions as well as a German and Spanish translation demonstrate the demand and need for a convenient compendium in managing unfamiliar emergency medical problems encountered by a practitioner. It contains an extensive collection of information not readily available elsewhere, written in a succinct style. It offers guidance not only in matters of medical practice but also in the related fields of law, conduct, and philosophy. Twenty-five qualified contributors provide authoritative consultation in a great breadth of subject matter. Any differences that may exist in their individual perspectives are adjusted under the direction of the editor, Dr. Birch, to eliminate apparent inconsistencies which might harass the reader.

Virtually inevitable in such a text, there are shortcomings: lack of comprehensiveness; dangerous oversimplification of some diagnostic and therapeutic procedures; failure to indicate where emergency management should be supplemented by expert assistance, weighed against

the risks of transportation or delay; and, particularly for American physicians, an unfamiliar British Drug Nomenclature and designation of sources of drugs, laboratories, and other facilities appropriate only for British practitioners.

Omission of therapeutic procedures such as the use of oxygen for left ventricular failure could have serious consequences, albeit no less so than from employing inadequately discussed procedures such as the methods for controlling anticoagulant therapy. The suggestion—"when prothrombin activity cannot be estimated, some measure of control may be given by looking for red blood cells in the urine"—implies acceptance of a hazardous technique for controlling therapy under conditions wherein the therapeutic agent becomes more dangerous than its omission.

Frequent revisions, which have kept it abreast of current medical thought, testify to the reliance placed upon it by physicians the world over. Propitious indexing makes the content rapidly accessible, but the quality of the binding is inadequate for a reference book that will be used frequently. Despite minor shortcomings, the topics discussed run the gamut of almost all exigencies that may arise, whether on land, at sea, or in the air.

William H. Wehrmacher, M.D.

Medical Care of the Adolescent. J. Rosewell Gallagher, M.D. $10. Pp. 384. New York, Appleton-Century-Crofts, Inc., 1960.

The author has brought together in one book known information of various fields of medicine that are common to the adolescent years. Great stress is placed on trying to understand this age group and how to get an adequate expression of their problems. The importance of treating and understanding the emotional upheavals along with the physical problem is emphasized. Adolescents are overconcerned with themselves and demand sincere and full attention from their physicians before cooperating to their best ability.

There is some repetition but this provides emphasis. The effects of creating unnecessary invalids with the diagnosis of heart disease when only a functional murmur is present is well presented.

Pancreatitis is given unusual prominence in such a limited volume but is apparently justified by the author's experience. The possible relationship of this disease to crash diet fads in teenage athletes is suggested.

Any physician dealing with adolescents will find this book instructive and helpful in handling these maturing men and women.

L. Martin Hardy, M.D.

The Teen-Age Years: A Medical Guide for Young People and Their Parents. Arthur Roth, M.D. $3.75. Pp. 288. New York, Doubleday, & Company, Inc., 1960.

This book is a medical approach and guide to various adolescent problems that confront young people and their parents.

The author emphasizes and discusses the numerous physical variations, patterns of growth, and emotional reactions that are within the realm of normal. Children and parents need frequent repetition of these facts. Giving pills to a child for growth at his insistence after telling him he is normal, is hardly consistent or conducive to lasting confidence.

The problem of sex is brought into the discussion more frequently than is recognizable in the average teenager's dilemma. However, the frank dissertations and examples should stimulate the inhibited to ask their physicians for true answers and clarification of these "delicate" questions.

The examples of erroneous and evasive remarks made by unthinking or embarrassed adults should give the discerning teenager an explanation for some of his misconceptions. Parents will profit by these examples and avoid the same pitfalls.

Diseases and accidents common to children are discussed in understandable terms. Woven throughout these specific medical problems are explanations of cause and effect that should dispel many "old wives tales."

L. Martin Hardy, M.D.

Current Therapy—1960. Ed. by Howard F. Conn, M.D. $12. Pp. 808. Philadelphia, W. B. Saunders Company, 1960.

This volume has appeared annually for more than a decade, giving the latest information on therapeutic procedures by various medical authorities. It is aimed at the busy physician who is overwhelmed by the avalanche of medical literature.

Information is practical. The reader is offered

one or more established ways to treat a given ailment, and the most effective therapeutic agents, their proper dosage, side effects, and expected response are stressed. The material is concise, authoritative, and unbiased.

Fourteen sections deal with disease processes of the major systems of the body. Section 15 considers physical and chemical injuries. It includes also a short discussion on 130 miscellaneous poisons, along with the principle active ingredients in various commercial products. The appendix (Section 16) contains additional data on drugs mentioned in the book and a table of pediatric dosages.

This is a large volume but so well indexed the desired information can be found within a few moments. Conn's book should be in the office library of every practicing physician.

T. R. Van Dellen, M.D.

Arthritis and Allied Conditions. 6th ed. Joseph Lee Hollander, M.D., Editor. $20. Pp. 1306. Philadelphia, Lea and Febiger, 1960.

This is the sixth renewal of an already outstanding textbook on rheumatology. The first edition was published in 1940 by Bernard T. Comroe, M.D. The sixth edition comprises the authoritative writings of thirty-nine authors who are acknowledged leaders in the fields of arthritis, rheumatism, gout, and collagen diseases. The book is divided into eleven chapters under eight section editors. The roster of writers reads like a Who's Who of rheumatology. Ten of the contributors are past presidents of the American Rheumatism Association and one, of the Canadian Arthritis and Rheumatism Association. These and each of the other contributors are experts on their respective subjects.

There are, extant, some good texts on rheumatology, but this book stands supreme in its field. Every aspect of arthritis and allied rheumatic diseases is covered competently and authoritatively in great detail, and each chapter contains a complete reference bibliography. It is profusely illustrated with 417 pictures, line drawings and tables plus numerous other tabulations. Here is a masterly encyclopedia of everything presently known in the field of rheumatology. In most chapters there are blocked-off sections listing the cardinal points of importance. These are excellently executed and greatly simplify the task of the reader in reviewing and extracting the meat from these chapters. Sections on diagnosis and treatment are exceedingly complete, up-to-the-minute, and detailed. Rehabilitation, gold therapy, and steroid therapy are extremely well covered. Parenteral steroid therapy is discussed in detail by the pioneer in this method. Serologic tests for diagnosis are discussed completely. Lupus erythematosus and other collagen diseases are very well presented.

There is, I believe, no question which the reader could ask regarding rheumatology whose answer is not found somewhere in this splendid textbook. In the reviewer's opinion, this is the most outstanding source book on information ever printed on this subject. It is indispensable reading for the interested medical student, general practitioner, internist, and orthopedic surgeon and a must for the specialist in the field of rheumatology.

Stanley Fahlstrom, M.D.

Pain and Itch. Ciba Foundation Study Group No. 1. Ed. by G. E. W. Wolstenholme and Maeve O'Connor. $2.50. Pp. 120. Boston, Little, Brown & Co., 1959.

A meeting was held on March 10, 1959, in honor of Dr. Y. Zotterman. To appreciate this small volume of 120 pages, one must know who attended this meeting: The Rt. Hon. Lord Adrian, G. D. Dawson, E. Dodt, W. W. Douglas, G. Gordon, A. Iggo, C. A. Keele, K. D. Keele, L. Kruger, E. K. H. Kugelberg, S. Langdren, D. Neil, J. M. Ritchie, A. N. Shanes, W. B. Shelley, D. Taverner, Sir Francis Walshe, A. G. M. Weddell, D. Whitteridge, and Y. Zotterman.

This volume brings up-to-date, by numerous papers, our clinical, physiological, and electrophysiological knowledge of pain and other sensations in the skin, as well as the mechanism of tickle and touch. For anyone interested in this important subject, both from the clinical and physiological standpoints, it is urged that he read this volume. The volume is written quite simply. There is much discussion and an extensive bibliography. I think every neurologist, neurophysiologist, and dermatologist should include it in his library.

Alex J. Arieff, M.D.

OFFICIAL BUSINESS

House of Delegates

First Session
Monday, May 23, 1960

The Annual Meeting of the House of Delegates of the Illinois State Medical Society was convened in the Louis XVI Room, Hotel Sherman, Chicago, Illinois at 8:25 p.m., President Joseph T. O'Neill, presiding.

THE PRESIDENT: Gentlemen of the House of Delegates, the first meeting of the House has been called to order. May I welcome you to the Annual Meeting of your State Society and may your deliberations be considered in a manner which is to the benefit of the Society and the people of Illinois.

In order that we may be organized officially, I should like the chairman of the Credentials Committee, Dr. Carl E. Sibilsky, to report if a quorum is present.

DR. SIBILSKY: There are sufficient counties represented and sufficient delegates certified and registered to give us a quorum.

THE PRESIDENT: The official count will be announced to you later, when completed. Whenever you are ready with the official count, Dr. Sibilsky, will you please notify the Chair?

Now then, in several of the State Societies that I have attended in the last year or two, it has been customary to call on the President of the Women's Auxiliary to the State Society to deliver the invocation. This idea has appealed to me particularly because I think they should have some participation in the State Society meetings and, therefore, I have asked Mrs. John Van Prohaska, President, Women's Auxiliary, to give the invocation to you tonight. Will you please stand.

MRS. VAN PROHASKA: O God and Father of mankind, as we gather together this week, help us to find thee by understanding our fellow man.

Help us to bring our finest capacities and greatest potentialities to the task we have before us.

Grant that ere our life is done, we may, under thy tuition, become true master workmen who know the art of a just and valiant life.

May we be shepherds of the spirit as well as masters of the mind so that we can recall the past benevolently, living the present wisely and face the future courageously.

Help us, O Lord of all, to know thy way as we move about our work.

Our ancient sages tell us that the world rests upon three things—truth, justice, peace. May we today translate these freely to men. Where there is no truth, there can be no justice; where there is no justice, there can be no peace.

Thus enlighten our minds with the pursuit of truth and ennoble our hearts with the promptings of justice and endow our hands with the task of peace.

May it be said of each of us that the world is a better place because of our work in it. Amen.

THE PRESIDENT: At this time, the Hotel Sherman Convention Manager, Mr. Earl Benedict, wishes a word with you.

MR. BENEDICT: Fellows, it hardly seems like a year because you look just the same tonight as you did a year ago and, of course, I think that is really something.

However, we are certainly mighty glad to see you here. We know you are going to have a great convention.

I know one thing, and that is that you do have a great display downstairs. I cannot tell you about the program because I am not a doctor. However, from this display and the exhibits, I am sure you are really going to have something to see.

Now, Mr. President, on behalf of the Hotel Sherman, it is my pleasure to present you with this gavel. We are sure that you will not have to use it because these fellows look to be in good mood tonight. However, I am sure that you will take this home to your grandchildren and God bless you.

(Presentation and applause)

THE PRESIDENT: On behalf of Mrs. O'Neill and the grandchildren, I would like to thank the Hotel Sherman. I would also like to thank you, Mr. Benedict, personally. It has been a pleasure to have worked with you over the years.

The next item on the agenda is the roll call by the Secretary. However, if you wish to present a motion that the count of the Committee on Credentials constitutes the roll call, the Chair will be glad to receive such a motion. (Adopted)

THE PRESIDENT: The Chair would be glad to entertain a motion for the approval of the minutes of the May, 1959 meeting of the House as published in a supplement to the Illinois Medical Journal. (Moved and Seconded)

MEMBER: In connection with the minutes in May, I think there is one error in connection with the Reference Committee report.

That is on page 67, where it is said, "Mr. Chairman, I move that these recommendations be submitted to the Committee on Aging for consideration and report back to the House of Delegates."

However, I believe that the doctor deleted that part from the report and that the entire report was acted upon by the House of Delgates.

THE PRESIDENT: If there is no objection, the minutes will stand as corrected. (Adopted)

We are now ready for the approval of the minutes of the December, 1959 meeting, as published in the March, 1960 issue of the Illinois Medical Journal. (Adopted)

THE PRESIDENT: It now becomes my privilege, gentlemen of the House, to present to you the Outstanding Practitioner of the Year in Illinois as selected by your committee.

The selection of your committee is a man who has rendered unselfish service not only to his patients for the last thirty-four years, but to his profession and to his community as well.

He was born in 1897 on a farm in Redwood Falls, Minnesota. After receiving his Master's Degree from Pennsylvania State College in 1919, he taught chemistry for two years at Northwestern University. However, an early childhood desire to be a physician asserted itself. He entered Northwestern University Medical School, drove a cab at night to pay his way and received his M.D. Degree in 1926.

He took up the practice of medicine in Cicero, in a location where he is today. A driving force in the MacNeal Memorial Hospital of Berwyn, he helped develop that hospital from fifty to two hundred seventy-six beds.

He is a councilor of the Chicago Medical Society, President of the Illinois Academy of General Practice, and a member of this House of Delegates.

He is a civic leader and is particularly interested in helping crippled or retarded children. For the last twenty-six years he has been an adult Bible class teacher in the Clemer. Presbyterian Church of Cicero and, at times, has substituted in the pulpit.

It is fitting, therefore, that we honor this man for his long service to the public, his contributions to the better-

ment of medical care and his devotion to community welfare.

I will ask Dr. Piszczek and Dr. Mrazek to escort Dr. John Colville Smith to the rostrum.

(Dr. Smith was then escorted to the rostrum.)

Dr. Smith, it is with great pleasure that I present to you this certificate which is emblematical of your selection of the Illinois General Practitioner for 1960, and this album, which is an illustrated biography of the fine service you have rendered.

Also, now, before you reply, I am going to ask the escorts to also bring Mrs. Smith to the rostrum.

(Mrs. Smith was then also escorted to the rostrum.)

DR. JOHN C. SMITH: May I just say that words cannot express the feeling that comes into my heart tonight. Thank you very much for this honor. I never expected to attain this and never dreamed of it and, thirty-four or thirty-five years ago, when I finished driving a Yellow cab, I did not think it possible for a cab driver to ever be in this place.

Now then, at this time, I would also like to present my wife. (Applause)

I would like to say that without her help during these many years, through medical school and after medical school—without her guidance, financial and otherwise, her advice in connection with the practice of medicine and all of her other help, it would have been impossible for me to have ever reached this goal.

I would also like to thank all of the many other people who have helped me. They have done a tremendous job. I have reference to the staff at the hospital, the Douglas Park Branch of my Medical Society, the Medical Society and all of my other friends. To them I owe this honor and everything else. Thank you very much. (Applause)

THE PRESIDENT: And now, Dr. Smith, I formally present this certificate to you and Mrs. Smith. I also give you this book which I know you will keep in much better shape than he would, Mrs. Smith.

(Presentations and applause)

THE PRESIDENT: Gentlemen, over the years it has been customary for the President to deliver an address before the general assemblage of the Illinois State Medical Society. As a matter of fact, I think it is constitutionally mandatory that he do so.

When the opportunity to address you came up for me this year I asked if I might not deliver this address to the House of Delegates because I think anything I have to say is probably in the realm of the socioeconomic branch of medicine. I do not have any particularly profound observations to make. I have no large dissertation to give you but there were a few things that I would like to say to you and, of course, these thoughts I have transmitted to a memorandum in order to be sure to give them all to you.

(Presidential address.)*

*See June Issue, IMJ, p. 379.

Now then, is the Committee on Credentials ready with a final report?

I will ask Dr. Allison L. Burdick and Dr. Lee N. Hamm to come up here to the platform.

Gentlemen, Dr. Hamm is your First Vice-President and Dr. Burdick your Second Vice-President this year. (Applause)

DR. SIBILSKY (Chairman, Credentials Committee): Mr. President, we have sixty-two counties represented, with a total of 179 certified delegates.

Mr. President, I move that this constitute the voting strength of this House of Delegates this evening. (Adopted)

THE PRESIDENT: Now I think that while all are fresh and before we get tired out that I would like to introduce some of the people who are going to be associated with us this coming year and for a good many years to come.

You will remember that an ad hoc committee was appointed. They rendered a report at the May meeting in connection with progress and after a great deal of searching and with the help of people whose business it was to find the right man for the right job, they have come up with a selection which has been presented to the Executive Committee of the Council, was presented to the Council and was acted upon by the Council.

I don't know of any job that was done in the State Society this last year that could compare to the terrific work that the ad hoc committee accomplished. They spent long, tedious hours going over reports of the various people. They met many, many times, sacrificing their time and money so that we might have an administrative force who could do some things for us.

I think that this House of Delegates should give a tremendous hand to the ad hoc committee, composed of Percy Hopkins, Chairman, Lester Reavley, C. Paul White and Leo Sweeney.

Gentlemen, I wish they would stand and I think they are all deserving of your appreciation. (Applause)

Now then, as a result of their deliberations and their sound and mature judgment, they all being past presidents of this Society, they have come up with four young men who are to help us carry on the work of the society from an administrative standpoint.

I am now going to call on Mr. Robert L. Richards, former associate secretary of the Pennsylvania State Medical Society, presently secretary of the Society of Internal Medicine, a very warm and very fine gentleman whom we, in our short association, have learned to regard with a great deal of affection.

I would like first to present him to you and then have him give you a few remarks of what he has in mind and then, in turn, present the other members of his team.

MR. RICHARDS (Executive Administrator):*

THE PRESIDENT: Before we leave the subject of staff, may I call your attention to and ask you to stand and give a great hand to a very fine doctor, who took up the reins when we lost our beloved Harold Camp last October and who set aside many of the things he would have liked to have done because he had devoted a full life to medicine and its various branches, who very willingly said to your Executive Committee and your Council, "I will be very glad to fill in until you can get someone whom you want permanently." Medicine owes a great deal to this man. He has filled in admirably. Everything has run a great deal more smoothly because of his guidance and I think we ought to give a standing ovation to a great man, a fine dcotor, a great administrator, Dr. George Lull.

(Rising applause)

DR. LULL: Gentlemen, this moves me very deeply.

Mr. President, thank you for your very kind words. I was called upon to pinch-hit and, as you know from watching ball games, a pinch-hitter very often strikes out. However, I hope I have not struck out. I have not made any home runs. I have stayed in more innings than I expected to and probably have gotten a lot of bases on balls. However, thank you very much. (Applause)

THE PRESIDENT: Practically all of the reports of the officers and of the constitutional and Council appointed committees have been published in your handbook. You have had an opportunity to read them through their appearance in the Journal of the Medical Society—the March and April issues.

There are some supplementary reports which I believe you have also been provided with.

Will you indulge the Chair if he doesn't call for these reports? However, if there are any further supplementary reports which the officers or the Councilors or the various committees wish to make, the Chair will be glad to hear them at this time. I specifically have reference to those which have not been mimeographed and published.

The Chair recognizes Dr. James Hutton of Chicago, a Past President of this Society.

DR. HUTTON: Mr. President, Members of the House of Delegates: The Committee on Medical Licensure did not have a meeting this year. However, just a few days ago we had some information which seemed to make it advisable to make a supplementary report.

Two years ago we made a recommendation in the report of the committee that we request the assignment of an assistant where they use the medical examining committee in departments of registration and education. That idea

*See page 98 for this report.

was approved by the House and was embodied in a bill passed by both Houses of the Legislature. However, it was vetoed by the Governor.

We now have information that the Attorney General might look with favor on the introduction of another bill along the same lines and the committee is, therefore, renewing its recommendation at this time.

I should say that the committee has not been together — they have been polled by letter and all, I think, but two have been heard from as favoring this action.

THE PRESIDENT: That report you have in your packet and if you wish to mark it now, it will be referred to Reference Committee 4.

Are there any further reports from any of the officers.

DR. E. S. HAMILTON: The day before yesterday I received a telegram which I would like to read to you, with the indulgence of the Chair.

"It is imperative that a flood of letters, telegrams and telephone calls be directed immediately to the House Ways and Means Committee urging that no action be taken on the Forand type or Fleming type legislation since hearings have not been held on the most recent proposals. The committee should be urged to conduct further hearings after Congress adjourns in July. Please contact as many physicians and as many of our allies as possible urging action immediately. We must act now since the House Ways and Means Committee will arrive at a decision in regard to this by Wednesday or Thursday of next week."

I might say that this letter was from Joe Stetler.

Now then, in considering what to do and how this could best be accomplished, it was our opinion that it was too late to send out telegrams to all of the officers of the Illinois State Medical Society and that probably here would be the best place to take that action.

Accordingly, I am making this suggestion to you. In Chicago we have two members of the Ways and Means Committee from Illinois. One of them is Tom O'Brien of Chicago and the other one is Noel Mason of Oglesby, Illinois.

Now then, each has been given an envelope and a piece of paper. We would appreciate very much if, again with the indulgence of the Chair, we could have five minutes so all of you who live in Chicago can write a letter to Tom O'Brien. All of you living downstate write to Mr. Mason. Their addresses are "Post Office Building, Washington, D. C." If, in this letter, you will give some reasons why you believe the Ways and Means Committee should not vote out either the Forand or the Fleming type of bill, we will be very happy to see that these get mailed.

Of course, I would suggest that some of the reasons are these:

1. They are too complex at present.
2. They have not been studied adequately.
3. There is no proof that they are necessary or that they will meet the need which is claimed for them.
4. That, in our opinion, imposing more tax is not going to solve the problem of the aged.

If you will write such a letter, now, and if you will sign your name and home address, after five minutes we will pick up the letters and mail them tonight so that tomorrow, or Wednesday at the very latest, they will receive these personal letters.

I would request that time, Mr. President, in the name of your Public Relations Committee. (Request granted and a five minute recess ensued.)

THE PRESIDENT: You have in your handbook the list of Reference Committees. In the interest of brevity, I shall not read them in full, unless it is your desire. However, I would like to read the names of the chairmen and a few changes which have come up.

I first refer to the Committee on Reports of Officers, Councilors, Delegates to the AMA; the Chairman of which is Dr. George B. Callahan.

Dr. Lambert F. Mammoser of the Irving Park Branch is unable to serve on that committee due to a death in his family and the Chair has therefore appointed Dr. Maurice Houten of the Chicago Medical Society to take his place.

In connection with the Committee on Reports of Constitutional Committees and the Illinois Medical Journal, Dr. John R. Wolff, Chairman, no change.

On Reference Committee on reports of Council Committees No. 1, to that committee add the name of Edward L. Hayes of Kankakee County.

With regard to Reference Committee on Reports of Council Committees No. 2, no change.

With regard to Reference Committee on Constitution and Bylaws No. 3, no change.

With regard to Reference Committee on reports of Council Committees No. 4, no change.

Also, in connection with Reference Committee on reports of Council Committees No. 5, no change.

When the reading and presentation of resolutions has been completed, will the chairmen of these committees please come to the front and receive the portfolio of the resolutions which have been assigned to them.

RESOLUTIONS

Adams County Medical Society

WHEREAS: Physicians everywhere are greatly interested in education, especially of children; and

WHEREAS: The Soviet goal is to pass the U. S. and gain world leadership and world communism by education, hard work and scientific supremacy; and

WHEREAS: We are, therefore, engaged with Russia in a "cold war of the classrooms," which we must not lose, as such an educational battle may determine the world struggle between communism and the free peoples, and

WHEREAS: The Adams County Medical Society for a number of years has carried on a program of giving recognition for high academic scholarship achievement in the high schools of Quincy and Adams County, and

WHEREAS: This program has been lauded by the American Medical Association in the J.A.M.A. and the PR Doctor, now

THEREFORE BE IT RESOLVED: That the Council of the Adams County Medical Society recommends to the Illinois State Medical Society that it encourage its component county medical societies to carry on similar educational programs in their respective communities; incidentally this will prove to be one of the best forms of good public relations for the profession and, at the same time, will reveal to the public that medicine is anxious to do its part to help win the "cold war"; that copies of this resolution be promptly sent to the Secretary of the Illinois State Medical Society for presentation to the House of Delegates at the May 1960 meeting.

THE PRESIDENT: Please label this Resolution No. 1; assign it to Council Committee No. 5.

Knox County Medical Society

WHEREAS: A great many physicians who are not now covered by Social Security desire such coverage; and

WHEREAS: Every other profession is now covered by said Social Security with the sole exception of the aforementioned physicians; now

THEREFORE, BE IT RESOLVED: That the Illinois State Medical Society poll the members of each of its component societies to determine definitely whether or not the majority of its membership desire to be covered by Social Security and if they do, that the delegates to the American Medical Association from the Illinois State Medical Society be instructed to bring this matter before the House for action.

THE PRESIDENT: Label this Resolution No. 2; assign it to the Constitutional Committee.

Kendall County Medical Society*

THE PRESIDENT: Kendall County—1 will be No. 3; assign it to Reference Committee No. 5. Kendall County—2 will be No. 4; assign it to the Constitutional Committee. Kendall County—3 will be No. 5; assign it to the Constitutional Committee. Kendall County—4 will be No. 6; assign it to the Constiutional Committee. Kendall County

*See April Journal for Kendall County resolutions No. 1-8, pages 310-313

—5 will be No. 7; assign it to Reference Committee No. 2. Kendall County—6 will be No. 8; assign it to Reference Committee No. 2. Kendall County—7 will be No. 9; assign it to the Constitutional Committee. Kendall County—8 will be No. 10; assign it to Reference Committee No. 2.

Label that Resolution No. 10.

Kendall County Medical Society Resolution — 9

WHEREAS: Publicity of the evils and the derogatory elements of medicine are notably always present in the eyes of the public; and

WHEREAS: The virtues of ethical, humanitarian practices of dedicated physicians are inadequately brought before the public; and

WHEREAS: Medicine is practiced at a higher level of ethics than most professions and is worthy of more laudable publicity at this time; now

THEREFORE BE IT RESOLVED: That the Illinois State Medical Society and the American Medical Association step up their program of laudable publicity for public consumption using all the available channels of communication to enhance the dignity and virtues of medicine.

THE PRESIDENT: Label this Resolution No. 11; assign it to the Constitutional Committee.

Saline-Pope-Hardin County Medical Society

WHEREAS: There is urgent need for action to combat Forand type legislation; and

WHEREAS: The American Medical Association has recommended a program of action, which has been studied, and recommendations made by the Illinois State Medical Society's Committee on Aging; and

WHEREAS: The House of Delegates of the Illinois State Medical Society in session on December 12 and 13, 1959 recommended to the Council a procedure for action; now

THEREFORE BE IT RESOLVED: That this House of Delegates concur in, and support the action of the Council in preparing and presenting a low cost insurance program to the people over 65 in the State of Illinois; and

BE IT FURTHER RESOLVED: That a copy of this resolution be sent to each County Medical Society in the State of Illinois, requesting that each Society prepare and present a similar resolution to the House of Delegates at its meeting in May, 1960.

THE PRESIDENT: Mark that Resolution No. 12; assign it to Reference Committee No. 2.

Williamson County Medical Society

RESOLVED: Recommending that the members of the Williamson County Medical Society request that the Council and the House of Delegates of the Illinois State Medical Society start negotiations through an appropriate committee for a better insurance plan than the present Blue Shield general certificate plan covering the over 65 years of age group, living on Social Security benefits.

We feel the programs should embody the following features:

1. Premiums and benefits should increase in proportion to Social Security benefits.
2. The fee schedule should be based on the California Relative Value Scale.
3. Furthermore, the individual physician should not be responsible to determine the eligibility for the recipient of this program.
4. Further, that negotiations should be conducted with other interested insurance companies.

THE PRESIDENT: Label that No. 13; assign it to Reference Committee No. 2.

Chicago Medical Society

WHEREAS: Dr. Rollo K. Packard, a distinguished member of the Illinois State Medical Society, was taken from us by death on March 28, 1960; and

WHEREAS: Dr. Packard was very liberal of his time and efforts on behalf of the Illinois State Medical Society; and

WHEREAS: He served as Council member and president of said society and represented it most ably as a delegate in the House of Delegates of the American Medical Association; and

WHEREAS: He demonstrated his interest in the public by his activities and efforts in working for prepaid medical care plans for the citizens of our state; now

THEREFORE, BE IT RESOLVED: That the Illinois State Medical Society by action of its House of Delegates recognize his loss to the society and to his profession by having this resolution engrossed and published as part of the minutes of this meeting; and

BE IT FURTHER RESOLVED: That a copy be sent to his family with an expression of the deepest sympathy from its members.

THE PRESIDENT: That is No. 14 (Adopted by House as a whole, without reference)

John Lester Reichert, M.D.

WHEREAS: Dr. W. L. Crawford has served as Chairman of the Committee on the Maternal and Child Care of the American Medical Association since its inception, and Dr. Dean W. Roberts has served on the Committee on Indigent Care since its inception, both of these committees having been credited in 1949; and

WHEREAS: The work of these two members of the Illinois State Medical Society has been brilliant, and has demonstrated a real familiarity with the work of the committees which has resulted in significant progress in the solution of many problems involved; and

WHEREAS: The efforts of these two physicians in their respective fields have reflected great credit on the medical profession, the American Medical Association and the Illinois State Medical Association; now

THEREFORE BE IT RESOLVED: That the Council of the Illinois State Medical Society in session April 24, 1960, commends Dr. W. L. Crawford and Dr. Dean W. Roberts for their outstanding service to the medical profession, and to the citizens of our country; and

BE IT FURTHER RESOLVED: That this resolution be presented to the House of Delegates of the Illinois State Medical Society at its May, 1960 meeting. (Adopted without reference)

Lake County Medical Society

Read by Donald Nellins, M.D.

WHEREAS: The number of malpractice suits against physicians and their employees is steadily increasing with a corresponding increase in malpractice insurance rates; and

WHEREAS: The filing of a malpractice action in court causes substantial harm to the reputation and practice of the physician involved; regardless of the merits of the claim; now

THEREFORE, BE IT RESOLVED: That the Illinois State Medical Society appoint a committee to investigate the establishment of a Screening Panel made up of members of the Illinois State Medical Society and the Illinois State Bar Association whose purpose would be to serve as a source of consultation for attorneys and clients prior to the filing of malpractice suits and whose objectives would be to prevent, where possible, the filing in court of suits against physicians and their employees where the facts do not support a reasonable inference of malpractice and to make possible the fair resolution of actions against physicians when the claims appear to be well founded.

THE PRESIDENT: This is Resolution No. 16; assign it to the Constitutional Committee.

Sangamon County Medical Society

WHEREAS: The Drug Standards and Procedures and Rules and Regulations of the Illinois Public Aid Commission, adopted in September, 1957, provide that drugs shall be supplied to public assistance recipients by participating pharmacies only upon the written and signed order of a physician or a dentist; and

WHEREAS: Payment for prescribed drugs may not be made if the basis for the billing from the participating pharmacy is an oral order from a physician or a dentist; and

WHEREAS: The Illinois State Medical Society Advisory

Committee to the Illinois Public Aid Commission did advise all physicians providing services to recipients as follows in April, 1960:

"Physicians participating in the Illinois Public Aid Commission's medical care program are reminded that the Commission's policy provides that drugs shall be furnished to public assistance recipients by a pharmacy only on the basis of a written prescription prepared and signed by the physician on the Commission's official drug prescription form, IPAC Form PP-215 (Cook County Form PP-215C), which must be presented to the pharmacy by the recipient or, in case of extreme illness or disability, by an authorized person acting in his behalf," and

WHEREAS: The members of the Sangamon County Medical Society feel that this method of providing drugs to Public Aid recipients is frequently unrealistic and impractical; and

WHEREAS: This procedure is not in accordance with customary and acceptable practices of supplying drugs for private patients by telephone and verbal orders to pharmacists; and

WHEREAS: The members of the Sangamon County Medical Society believe that the IPAC procedure is not compatible with the high quality of medical care they are trying to provide for these recipients; now

THEREFORE, BE IT RESOLVED: That the Illinois State Medical Society Advisory Committee to the Illinois Public Aid Commission request a change and modification of this ruling so as to permit the oral (telephone) ordering by physicians of prescriptions to Illinois Public Aid recipients.

THE PRESIDENT: This is Resolution No. 17; assign it to Reference Committee No. 1.

Medical Examining Committee

Read by Burtis E. Montgomery, M.D.

WHEREAS: The Director of the Department of Registration and Education is authorized by the Civil Administrative Code to appoint other examiners under the terms of paragraph 60A, sub-paragraph 19, which states as follows: "Whenever the Director is satisfied that substantial justice has not been done either in an examination or in the revocation of or refusal to renew a license, certificate, or authority, he may order re-examinaiton or rehearings by the same or other examiners"; and

WHEREAS: Sub-paragraph 18 of paragraph 60A of the same code states as follows: "In making the designations of persons to act for the several professions, trades and occupations, the Director shall give due consideration to recommendations by members of the respective professions, trades, and occupations and by organization therein"; now

THEREFORE, BE IT RESOLVED: That the Council of the Illinois State Medical Society authorize the creation of a panel, the members of which shall be competent to serve as examiners in the basic sciences and clinical subjects and who would be willing, upon request, so to serve, and that the Council be so instructed by the House.

THE PRESIDENT: That is Resolution No. 18; assign it to the Constitutional Committee.

Medical Examining Committee

Read by Burtis E. Montgomery, M.D.

WHEREAS: The Medical Examining Committee of the Department of Registration and Education of the State of Illinois examines candidates for medical licensure in all subjects; and

WHEREAS: The Medical license of the state is granted to practice medicine in all its branches; and

WHEREAS: Medical Examining Committee feels that a good rotating internship is an integral part of the training of most physicians and particularly of generalists, which are in the greatest demand in the state; and

WHEREAS: The Medical Examining Committee has a rule requiring a rotating internship except in unusual circumstances; and

WHEREAS: The Committee feels that the judging of these circumstances would be best left in its hands and on an individual basis; and

WHEREAS: There is presently being much pressure brought to cause the committee to change its rule of the Legislature to enact new legislation; now

THEREFORE, BE IT RESOLVED: That this House of Delegates of the Medical Society of the State of Illinois go on record as supporting the Medical Examining Committee in its retention of the rule regarding rotating internship; and

BE IT FURTHER RESOLVED: That this House of Delegates recommends that the membership of the State Society be polled by mail as to their attitude toward this rule.

THE PRESIDENT: That is Resolution No. 19; assign it to the Constitutional Committee.

Sangamon County Medical Society

Read by Tom Harmon, M.D.

WHEREAS: The state dues of the members of the Illinois State Medical Society were increased by 50 per cent at the annual meeting in 1959; and

WHEREAS: The financial experience and the operation of the administration of the Illinois State Medical Society have not resulted in any deficit throughout many years of operation on the previous dues; and

WHEREAS: The Council of the Illinois State Medical Society has hastily and without adequate deliberation obligated the members of the State Society for greatly increased expenses by (1) the leasing of office space in Chicago for a period of 5 years at an annual rental of approximately $25,000.00 plus remodeling expenses (as compared to approximately $10,150.00 previously paid annually for space both in Chicago and Monmouth); (2) the employment of an Executive Administrator at an annual salary of $22,000.-00 plus an expense account of an unknown amount; (3) the employment of a Public Relations Director at an annual salary of $15,000.00 plus an expense account; (4) the employment of a Director of Scientific Activities at an annual salary of $15,000.00 plus an expense account; and (5) the employment of an Associate Editor of the Illinois Medical Journal at an annual salary of $9,500.00; and

WHEREAS: Despite these greatly increased financial obligations, the "downstate" members of this State Medical Society have been deprived of a "downstate" administrative office which has traditionally been so located for over 59 years; now

THEREFORE BE IT RESOLVED: That the members of the Sangamon County Medical Society voice their disapproval of such extensive and questionably wise or necessary expenditures; and

BE IT FURTHER RESOLVED: That the members of the Sangamon County Medical Society oppose any additional increase in the per capita dues for State Society members; and

BE IT FURTHER RESOLVED: That the members of the Sangamon County Medical Society urge all "downstate" County Medical Societies to fully consider these facts and join in this opinion.

THE PRESIDENT: This is Resolution No. 20; assign it to the Reference Committee on the Reports of Officers and Councils.

Jean Moore, M.D.

WHEREAS: The American Medical Association has, from the operational standpoint, modernized itself in the past 10 years and must continue to efficiently use its members dues and its members and employees time; and

WHEREAS: New needs arise for the efficient utilization of doctor's dues by both their state and their American Medical Association; and

WHEREAS: State and regional postgraduate meetings (The Chicago Medical Society's Clinical Conference, the American College of Surgeons regional meetings, the American Academy of General Practice's local area conferences, and state medical society meetings and postgraduate efforts) are doing an improved job of physician postgraduate education; and

WHEREAS: The physician attendance at the clinical sessions over the past 10 years has not justified the efforts of doctors or of the AMA's paid staff; and

WHEREAS: The record for the AMA Clinical Meeting from 1952 thru 1957 is as follows:

YEAR	PLACE	MD ATTENDANCE	COST	INCOME	LOSS
1952	Denver	2,614	$109,938	$45,430	$64,508
1953	St. Louis	2,730	118,029	62,866	55,163
1954	Miami	3,253	118,208	62,800	55,408
1955	Boston	3,779	122,207	69,450	52,757
1956	Seattle	2,813	124,118	59,475	64,643
1957	Philadelphia .	2,637	125,524	85,415	40,109

WHEREAS: It has cost our Illinois State Medical Society over $36,000 in a five year preiod to send our delegates to the Clinical Sessions which bill averages approximately $150.00 per day, per delegate in attendance; and

WHEREAS: A one and a-half day session of the AMA House of Delegates, at a central point, would care for the policy making decisions needed for American doctors, at less than half the cost to the physicians of each state of sending their delegates to a five-day clinical session; now

THEREFORE, BE IT RESOLVED: That this House of Delegates instruct its delegates to the AMA to introduce and work for the passage of a resolution that will save our members dues for better purposes, improve the efficiency of the AMA House of Delegates operation, render our public and our physician members better service, and recommend to the AMA Board of Trustees that the annual Clinical Session, except for a day and a-half to two-day session of the AMA House of Delegates be discontinued.

THE PRESIDENT: This is Resolution No. 21; assign it to the Reference Committee on Reports of Officers and Councils.

Effingham County Medical Society

Read by Dr. B. A. Samp

WHEREAS: The Council of the Illinois State Medical Society has publicized and has had introduced into the minutes of the Federal Legislative bodies a plan for providing medical care to persons over 65; and

WHEREAS: There may be no serious objection by the members of the Illinois State Medical Society to this plan; and

WHEREAS: There is no objection to this plan by the membership of the Effingham County Medical Society; but

WHEREAS: The action of the Council infers an action or resolution approved by the Illinois State Medical Society; and

WHEREAS: By the publicity given it, this action cannot be abandoned without serious embarrassment to the Society, and the profession as a whole; and

WHEREAS: Section 9, Chapter V of the Bylaws of the Constitution and Bylaws of the Illinois State Medical Society which refers to the House of Delegates reads, "It shall approve all memorials and resolutions issued in the name of the society before they shall become effective"; now

THEREFORE, BE IT RESOLVED: That the House of Delegates act to approve this resolution to make it effective; and

BE IT FURTHER RESOLVED: To instruct the Council that in the future any publication of action not formally approved by the House of Delegates be publicized only as contemplated action of the society.

THE PRESIDENT: This is Resolution No. 22; assign it to Reference Committee No. 2.

Will Grundy County Medical Society

Read by N. P. Primiano, M.D.

WHEREAS: Socialism is a form of government which transfers personal responsibility to the state; and

WHEREAS: A loss of personal responsibility must necessarily limit freedom of decision and action; and

WHEREAS: The strength of this nation and the welfare of its people have come from and continue to be dependent upon personal initiative and responsibility and freedom to act according to the individual conscience, within those limits determined by the freedom and rights of others; and

WHEREAS: The members of the Will-Grundy County Medical Society are disturbed by the constant encroachment of Socialism upon the freedom of the American citizen; now

THEREFORE BE IT RESOLVED: That the membership of the Will-Grundy County Medical Society oppose socialistic legistlation be it in the form of medical care or otherwise; and

BE IT FURTHER RESOLVED: That this Medical Society is unanimously opposed to HR 4700 — "The Forand Bill" — considering it a prime example of such socialistic legislation.

THE PRESIDENT: This is Resolution No. 26; assign it to Reference Committee No. 2.

Will Grundy County Medical Society — 2

Read by N. P. Primiano, M.D.

WHEREAS: Organized medicine has assumed that medical care of the aged, 65 years of age or over with limited income is a medical problem at least in part; and

WHEREAS: Representatives of the Illinois State Medical Society propose a fixed fee form of medical insurance program in the State of Illinois in conjunction with Blue Shield; and

WHEREAS: Such a program is offered as an alternative to the Forand Bill legislation; and

WHEREAS: Any fixed fee for services rendered would limit responsible and ethical practicing physicians of their constitutional right of decision and encourage their irresponsibility in their care of patients; and

WHEREAS: Only an increased and sustained responsibility of physicians can insure the best in medical services for people; now

THEREFORE, BE IT RESOLVED: That the Will-Grundy County Medical Society opposes any fixed fee Medical Service Plan for people age 65 or over with limited income on the basis that it would be an equally socialistic alternative to a government sponsored program; and

BE IT FURTHER RESOLVED: That the officers, councilors and delegates of the Illinois State Medical Society and the various County Societies of the state be informed of this considered opinion of the Will-Grundy County Medical Society.

THE PRESIDENT: This is Resolution No. 27; assign it to Reference Committee No. 2.

Will Grundy County Medical Society —3

Read by N. P. Primiano, M.D.

WHEREAS: The great majority of physicians in the past and present have been and are aware of the inability of certain people with limited income (whether elderly, disabled, chronically ill, or oppressed by various misfortunes) to pay for medical care; and

WHEREAS: Most physicians have in the past offered their services to all regardless of ability to pay; now

THEREFORE, BE IT RESOLVED: That the physicians of Will-Grundy Counties will continue to care for the medical needs of the indigent for little or no charge for services rendered; and

BE IT FURTHER RESOLVED: That the physicians of Will-Grundy counties will continue to render ethical services to people 65 or over with limited income at a fee commensurate with their ability to pay; and

BE IT FURTHER RESOLVED: That the people of this community be kept aware of the constant willingness and readiness by the physicians to show such charity and consideration, as these needs are made known.

THE PRESIDENT: This is Resolution No. 28; assign it to Reference Committee No. 2.

Will Grundy County Medical Society — 4

Read by N. P. Primiano, M.D.

WHEREAS: Inflation and the rising cost of living has made it difficult for our aging citizens to adequately plan for themselves a satisfactory retirement income; and

WHEREAS: Forced retirement at age 65 has become the by-word and policy of our industry and government; and

WHEREAS: Present Social Security benefits are inadeqaute to meet the current needs for our aging citizens; and

WHEREAS: Social Security benefits are not allowed an aging citizen, capable of further employment, should he seek to augment his income beyond certain limits; now

THEREFORE BE IT RESOLVED: That as individual citizens, and as physicians represented by the Will-Grundy County Medical Society, the Illinois State Medical Society, and the American Medical Association make every effort, directing all proper activity against all proposals that are inflationary, constantly making known to the public the sound reason for such stand; and

BE IT FURTHER RESOLVED: That these societies be instructed to actively support such legislation as will encourage individual planning for retirement as well as such legislation as will encourage our senior citizens to continue active and productive lives without economic penalty.

THE PRESIDENT: This is Resolution No. 29; assign it to Reference Committee No. 2.

Will Grundy County Medical Society — 5

Read by N. P. Primiano, M.D.

WHEREAS: We have seen the tremendous growth of voluntary health insurance companies; and

WHEREAS: We have seen the great contributions honest health insurance companies have made in providing protection to millions of people at fair and reasonable costs on a voluntary basis; now

THEREFORE BE IT RESOLVED: That the Will-Grundy County Medical Society reaffirm its faith in and support of the use of voluntary health insurance as an effective means of meeting the health expense needs of the public.

THE PRESIDENT: This is Resolution No. 30; assign it to Reference Committee No. 2.

I might add that I have just been informed that our girls had these resolutions delivered to them at five minutes of seven tonight and, having worked hard, have deposited them on the table in the back of the room. You may pick them up as you leave the room if you so desire. (Applause)

Will Grundy County Medical Society — 6

Read by N. P. Primiano, M.D.

WHEREAS: Both as free citizens and physicians we strive to protect the rights of the people to a free choice in the selection or rejection of their physician; and

WHEREAS: The recent action of the representatives of the I.S.M.S. and other state societies have by their actions given distinct advantage to one insurance company if not actually limiting the possible choice to this one company; now

THEREFORE BE IT RESOLVED: That the Will-Grundy County Medical Society opposes any plan which tends to limit any patient in his choice of an insurance company.

THE PRESIDENT: This is Resolution No. 31; assign it to Reference Committee No. 2.

Will Grundy County Medical Society — 7

Read by N. P. Primiano, M.D.

WHEREAS: The Will-Grundy County Medical Society recognizes that the problem of the indigent patient includes all ages, subject to a variety of illnesses and circumstances, and that the care of these less fortunate is primarily a local problem; now

THEREFORE BE IT RESOLVED: That appropriate committees of this Society make active efforts to coordinate all charitable and welfare aids available in the community to offer the highest possible level of medical care to those in need; and

BE IT FURTHER RESOLVED: That the public be informed of the help which is available to them, encouraging them to accept personal responsibility to seek help when needed.

THE PRESIDENT: This is Resolution No. 32; assign it to Committee No. 2.

McHenry County Medical Society

Read by M. Mijanovich, M.D.

(Letter prefacing resolution)

"Are Doctors Capable of Self-Government?

"The Illinois State Medical Society is an organization of over 10,000 members. The Illinois State Medical Society is controllable by the Council (16 members) according to our antiquated constitution.

"The McHenry County Medical Society proposes the following constitutional amendments to transfer control to the House of Delegates wherein each county society has representation and voice.

"We believe doctors *are* capable of self-government. If you do not believe this please oppose this vigorously.

Sincerely,

s/M. Mijanovich, M.D., Sec'y-Treas.
McHenry County Med. Soc. Delegate
Ill. State Medical Society."

BE IT RESOLVED that the following changes be made:

Article V of the Constitution should be deleted in total and replaced as follows:

ARTICLE V — HOUSE OF DELEGATES

Section 1. Subject to referendum pursuant to Section 3 of this Article, the control and administration of the Illinois State Medical Society shall be vested in the House of Delegates to be elected as provided in the Bylaws.

Section 2. The House of Delegates shall consist of delegates elected by component societies. Each member in the House of Delegates shall have one vote. The officers and councilors and the chairman of each committee of the Illinois State Medical Society shall have the privilege of the floor in the House of Delegates, but shall have no vote unless elected by a component society.

Fifty delegates representing not less than twenty counties shall constitute a quorum for the transaction of business.

Section 3. The House of Delegates may, at any time, by a majority vote refer and submit to the members of the Illinois State Medical Society defined questions affecting the policy of this Society, which, in the opinion of the House of Delegates, are of immediate practical consequence to the members of the Illinois State Medical Society and the public. The result of the referendum when duly ascertained by such vote, shall control the acts of the Illinois State Medical Society and of its officers, committees, agents and employees.

ARTICLE VI — COUNCIL

Sections 1, 2, 3 and 5 should be stricken.

Section 4 shall become Section 3; Section 6 shall become Section 4; Section 7 shall become Section 5, with an amendment added.

Sections 1, 2 and 5 shall read as follows:

Section 1. Subject to the action of the House of Delegates and during the interim between meetings of the House, the control and administration of the Illinois State Medical Society shall be vested in a board of trustees, herein designated, The Council.

Section 2. The Council shall consist of sixteen councilors elected by the House of Delegates (six shall be chosen from district number three and one from each of the other ten districts of the geographical area as of May, 1946), and one councilor at large (the immediate past president), and the officers of the I.S.M.S.

Section 5. Funds may be appropriated to encourage scientific investigation, medical education, and for any other purpose deemed proper and approved by the Council, and/or the House of Delegates.

THE PRESIDENT: This is Resolution No. 33; assign it to the Committee on Constitution and Bylaws.

Further, the Chairman of the Council has requested the privilege of the floor in order to make a statement.

DR. MONTGOMERY (Chairman, Council.): Doctor, is it my understanding that this takes away some of the powers of the Council as now set up under the Constitution?

DR. MIJANOVICH: Yes, I think it returns some of the vitality to this Congress.

DR. MONTGOMERY: Well, as you know, the Illinois State Medical Society is organized under the laws of the State of Illinois as a corporation and the corporation laws of the State of Illinois require officers and a board of trustees which have to do with the finances of an organization, and that also is a constitutional body as now set up in our Constitution.

Therefore, this resolution as it is now presented is illegal and unconstitutional, and I would move that this resolution be disapproved without reference. (Seconded)

THE PRESIDENT: It has been moved by Dr. Montgomery and seconded that this resolution be disapproved without reference. Is there any discussion?

DR. MIJANOVICH: I am not willing to concede all of the points that Dr. Montgomery makes.

I feel that if the control of the Illinois State Medical Society be vested in the House of Delegates and this is contrary to constitution as provided by the state, then something is amiss. I don't see where anything transferring control to an elected body from a smaller group of sixteen members which renders a group of over ten thousand people impotent, is a constitutional matter.

If this motion of Dr. Montgomery's is carried, I should be very disappointed because I don't believe that our powers and actions should be usurped by any sixteen members, no matter who they might be.

DR. VALE: In December, at the Committee on Constitution and Bylaws meeting, in the proposed amendments, it was stated that the Council of the Illinois State Medical Society is not a policy-making body and the question will be, in subsequent meetings of this House, whether or not the recommendations of that Committee on Constitution and Bylaws will be accepted.

This matter of the powers of the Council, I am sure, can be made to conform with our charter from the state. However, the core of the debate here is whether the Council shall be a policy-making body. In the opinion of the committee last December, it was that the Council should not be permitted the powers of making policy.

DR. R. E. HEERENS: Speaking neither for nor against this resolution, I think it is incumbent upon this body to examine any question brought before it through its usual means of Reference Committees, discussion and so on. I am heartily against acting on this matter too hastily. If any members have an objection to the present management, surely enough evidence can be brought into the Reference Committee, and such will be sustained.

I think we certainly ought to have a chance to discuss this in Reference Committee and not move this along in such a rapid hurry.

DR. M. R. SAXON: I presume that this is a democratic organization. Well, if it is, I would feel that I must go along with Dr. Heerens in seeing to it that any resolution propounded by the agencies of any County Medical Society have legal hearing.

DR. C. PAUL WHITE (Past President): I appreciate very much what the Committee from McHenry County is doing. However, I wonder why we don't realize we are dealing with our own men whom we have elected to the Council. I would think it would be more appropriate, if we did not exactly like the way these fellows did things within our respective districts, that we saw to it that there was a change made on the Council. I, myself, as well as most everyone here, belong to more than one organization and there are a lot of people who have to be governed by what their board of directors or trustees do. Constitutionally, that is the way we are set up and for a hundred years we have operated that way.

I do not want to cut off the possibility of a Reference Committee spending a lot of time listening to the pros and cons of this. However, it seems to me that it is a waste of time — it is an approach from an entirely wrong attitude. I feel that if we are not happy with the way someone we have elected approaches his duties, then I think that we had better wait awhile and make a change in a legal manner.

I would rather table this motion and let it come up at some future time if necessary.

I would like to move that we table this motion. (Seconded)

THE PRESIDENT: A motion to table cannot be discussed. Further, this motion takes preference. Now then, as I understand it, Dr. White, your motion was to table the motion made by Dr. Montgomery—is that correct?

DR. WHITE: Yes, that is right.

THE PRESIDENT: That is not applicable to discussion.

DELEGATE: This is not discussion — it is a point of order, sir.

The motion to table applying to this motion, applies to all of the motions which tie this matter together. If you table this, you are tabling also the resolution because this pertains to the motion and you cannot cut off part of the discussion — you cut it all off or you cut none off.

DR. WHITE: With the consent of my seconder, I move that this whole subject be tabled for this session. (Seconded)

THE PRESIDENT: The Chair will call for that question.

If you vote for this motion, you vote to table the whole matter — is that understood? If you vote against it, then it is still open.

Now then, all those in favor of tabling this whole matter, which includes the resolution and the motion, will signify by saying "aye"; all those opposed?

We will call for a rising vote. All those in favor will please rise. (Counting then ensued.)

Now then, all of them opposed, please rise. (Counting ensued.)

The result is 79 "yes" and 70 "no." The matter is tabled.

DELEGATE: I have a point of order. Could the parliamentarian tell us how many votes are necessary to table. I believe it must have two-thirds or three-quarters.

THE PRESIDENT: A majority is necessary. Are there any other resolutions?

R. E. Heerens, M.D.

These are amendments to the Constitution and Bylaws and, I am happy to say, they are in line with the comments made by Mr. Richards and also in line with the enlarging of our public relations program.

Incidentally, in reading the report of the Constitution and Bylaws, I think they probably omitted something. I am offering these so that the problem may be clarified at this session and so they may be acted upon by this House of Delegates this week.

The following amendments to the Constitution and Bylaws of the Illinois State Medical Society are proposed:

Amending Chapter IX, Committees: It shall be the purpose of these amendments to separate the Committee on Medical Service and Public Relations into two committees and to redefine the duties of said committees. The amendments shall include the separation in Section 1, a redefinition of duties of the Medical Service Committee in Section 3 and the addition of Section 9 Chapter IX to define the duties of the proposed Public Relations Committee. It is hereby proposed that Section 1, Chapter IX shall be as follows:

A Committee on Scientific Work.
A Committee on Medical Service.
A Medico-Legal Committee.
A Committee on Medical Education and Hospitals.
A Grievance Committee.
A Committee on Medical Benevolence.
A Committee on Public Relations,

and such other committees as may be necessary.

Such committees shall be elected by the House of Delegates, unless otherwise herein provided.

Section 2 — (no change)

Section 3 — The Committee on Medical Service shall consist of five members and the President and Secretary-Treasurer of the Society, ex-officio. Its activities shall be

carried on under the supervision and direction of the Council. Members of this committee shall be appointed by the Council for terms of three years; at the time of initial appointment, however, terms should be staggered with two appointed for three years, two for two years and one for one year.

This committee shall have charge of all legislative matters of interest to the medical profession in the State of Illinois. It shall maintain surveillance of all bills introduced in the State legislature having direct or indirect effect on the practice of medicine or of the health or sickness of the citizens of the State of Illinois.

The committee shall maintain effective liaison with the AMA Committee on Legislation and the AMA Washington office so that the Illinois State Medical Society will be fully informed and can perform as a vigorous member of the AMA on matters of federal legislation.

The Medical Service Committee shall adopt a legislative program for approval of the Council and promulgate this program among the members of the Society. A report of its activities shall be submitted currently to the Council and annually to House of Delegates.

Section 4 — (no change)
Section 5 — (no change)
Section 6 — (no change)
Section 7 — (no change)
Section 8 — (no change)

Section 9 — The Committee on Public Relations shall consist of ten members. Members of this committee shall be appointed by the Council for terms of three years: At the time of initial appointment, however, terms should be staggered with four appointed for three years, three for two years and three for one year.

The committee shall prepare and submit a public relations program for the Illinois State Medical Society to the Council for approval.

Such a program should include public service projects of long and short durations which will increase the public's esteem for the medical profession in Illinois.

The committee shall maintain a continuing surveillance and evaluation in Illinois, suggesting solutions and cooperating as the need arises.

Advising and assisting the Council, its committees and, when asked, the component societies, in the most effective use of all publicity media, shall be a major duty of this committee.

It shall disseminate to the members, public relations material suitable in Illinois for individual and area use.

Each component society shall appoint one member to act as advisor to this committee — thereby effecting a more vigorous statewide response to good public relations thinking.

The committee shall have the power to ask members to assist in the promotion of its program and to employ whatever professional assistance is needed, with approval of the Council.

Evaluation of the state of medical public relations and its program shall be made at each meeting of the Council and to the House of Delegates at its Annual Meeting.

DELEGATE: May I rise to a point of order? Dr. Heerens read the resolution. However, I would like to call the attention of the House of Delegates to the fact that he omitted the Committee on Prepayment Health Plans and I would like to suggest that this resolution should be looked over very carefully because I am afraid it has been written on the basis of the 1958 Constitution instead of the 1959 Constitution. Further, if the members here have followed Dr. Heerens carefully, you will see that all reference to the Prepayment Health Committee which was created by the House of Delegates last year has been entirely omitted from his presentation.

Therefore, if this resolution were adopted exactly as he stated it, it would be conflicting and incorrect as to the number of Sections.

THE PRESIDENT: This will be Resolution No. 33; assign it to the Committee on Constitution and Bylaws.

Now then, it is the understanding of the Chair that proposed changes in the Constitution and Bylaws must be read to the House of Delegates before they are discussed before the committee and before the committee comes in with a reference report pertaining to them. This will be done shortly.

Peoria Medical Society — 1

WHEREAS: Compulsory government medical service, such as the Forand Bill or other Social Security based schemes have been proposed; and

WHEREAS: The cost of all such compulsory government directed health plans is admittedly staggering and is projected onto the entire Social Security covered population; and

WHEREAS: Third party control is wasteful, inept, and has no place in the relationship between the patient and his doctor; and

WHEREAS: Compulsory medical care under Social Security gives minimal help at maximal expense, as only 11,390,000 of our 16,000,000 senior citizens receive Social Security payments; and

WHEREAS: 83 per cent of our senior citizens are now promptly paying their hospital bills in full (60 per cent by private insurance); and

WHEREAS: Only one out of four needy would be covered by Social Security; and

WHEREAS: Medical costs represent only 1/9 of the total personal need expense of the senior citizen; and

WHEREAS: The politician would, for votes, risk the destruction of the Social Security Act by the staggering tax burden to be placed on it; and

WHEREAS: Such compulsory medical schemes are but stepping stones in this destruction of basic free enterprise; now

THEREFORE, BE IT RESOLVED: That the 224 members of the Peoria Medical Society have voted to oppose all compulsory government and third party controlled medical care; and

BE IT FURTHER RESOLVED: That the Illinois State Medical Society expressed its opposition to the same by acceptance of this resolution; and

BE IT FURTHER RESOLVED: That a copy of this resolution and the action taken by the State Society be sent to each member of the United States Congress from Illinois without delay.

Peoria Medical Society — 2

WHEREAS: The Blue Shield fixed-fee plan has been presented by a segment of the Illinois Medical Society as a "substitute or else" alternative of compulsory federal medical service; and

WHEREAS: This plan introduces third party control between the patient and his doctor, which is the essence of any socialistic plan; and

WHEREAS: This fixed fee plan would attempt to reduce diseases, response to disease, response to treatment, and fees for service to standards; and

WHEREAS: Physicians would become unwanted investigators of the patient's income and net worth to determine if the Blue Shield plan they bought really applied; and

WHEREAS: "Our Secretary Page" of April, 1960 Illinois Medical Journal stated that the physicians have always taken care of the older patients of low income at a reduced fee; and

WHEREAS: Confusion and misunderstanding was evidenced by the membership when presented with the proposal; now

THEREFORE BE IT RESOLVED: That the Peoria Medical Society has voted to reject the Fixed Fee Blue Shield Plan for the medical care of patients 65 years and over; and

BE IT FURTHER RESOLVED: That the Peoria Medical Society opposes all third party fixed fee plans as threats to free enterprise; and

BE IT FURTHER RESOLVED: That we believe the physicians of this state will continue under free enterprise to render medical service to all citizens at fair fees for service and that none will be denied necessary medical care.

Peoria Medical Society — 3

WHEREAS: Socialism has as its goal the destruction of self-preservation under free enterprise; and

WHEREAS: The Social Security structure has become the playground for votes by politicians each election year, resulting in staggering projected tax increases on the worker and employer alike; and

WHEREAS: These zealots have announced a "problem" to be solved this election year, that of liberating the senior citizen from his medical burden by compulsion under Social Security; and

WHEREAS: Only 12 of 16,000,000 would be so liberated and 83 per cent are meeting their needs satisfactorily and only one of four needy would be helped by compulsion, all at great cost; and

WHEREAS: The medical profession under free enterprise has and is adjusting to successfully meet the changing medical needs of the senior citizen who is not now denied medical care; and

WHEREAS: The continued planned and deliberate attempts of zealots to socialize the medical profession has contributed to an alarming downward trend of young men seeking entrance into medical schools; and

WHEREAS: There does exist a "total care" problem in the preservation of our senior citizens, created in part by the loss of much liberty of pursuit of life and self-preservation under the protective Social Security System; and

WHEREAS: We, as citizens are desirous of helping the senior citizen meet his "total care" problem; now

THEREFORE, BE IT RESOLVED: That the Peoria Medical Society emphasizes that the "Problem" of the senior citizen is a total care problem; and

BE IT FURTHER RESOLVED: That the socialistic inspired attacks upon the medical profession cease; and

BE IT FURTHER RESOLVED: That under free enterprise, we grant our senior citizen the liberty to seek unlimited employment without penalty; provide, as in Peoria, agencies listing jobs available to him, and to realize tax relief is cheaper than dole through tax increase; and

BE IT FURTHER RESOLVED: That our prayer for our senior citizen be that politicians become statesmen and work for a self-sustaining and rewarding life for our senior citizen under free enterprise and that the vote of our senior citizen be earned not bought; and

BE IT FURTHER RESOLVED: That a copy of this resolution and the action taken by the State Society be sent to each member of the United States Congress from Illinois without delay.

THE PRESIDENT: Number these Resolutions 23, 24 and 25 respectively; they are all referred to Reference Committee No. 4.

W. O. Ackley, M.D.

WHEREAS: At the interim meeting of the American Medical Association held in Dallas, Texas, December, 1959, the House of Delegates favorably acted on a resolution delegating the power of appointment of examining physicians for the Class III Airman Certificate to the Civil Air Surgeon; and

WHEREAS: This constitutes the unnecessary entrance of federal politics into the practice of medicine, as well as the abrogation of the basic concept of the freedom of choice of physician by patient; and

WHEREAS: This examination follows the physical examination form ACA-1345 (11-57) of the Civil Aeronautics Administration; and

WHEREAS: This form does not require highly skilled or exceptional training to execute, nor special mechanical devices ordinarily available to examining physicians performing this type of over-all evaluation for usual insurance examinations; and

WHEREAS: The physicians of these United States have both skill and competence in this type examination; and

WHEREAS: The Class III Airman's Certificate refers to private pilots as contrasted with commercial or airline pilots; and

WHEREAS: It will work a hardship on the applicant to have to seek out a non-essential, so-called "specialist" in the field of examining pilots; and

WHEREAS: These examinations will be needed in almost every county in the country and the prospect of specialist examiners would have the effect of discouraging the growth of the Class III pilot group, the reverse of what is desirable; now

THEREFORE BE IT RESOLVED: That the Illinois State Medical Society at its regular meeting May 24 to 26th, 1960, go on record as favoring the proposition of having all duly licensed physicians considered qualified to perform Class III Pilot Medical Examinations; and

BE IT FURTHER RESOLVED: That the American Medical Association be petitioned through our delegates thereto to rescind and erase from the records the Dallas Resolution delegating to the Civil Air surgeon the power to appoint a limited number of examiners, which restriction appears to be without true cause or purpose.

THE PRESIDENT: This is Resolution No. 34; assign it to Committee No. 5.

J. E. Reisch, M.D.

This is a resolution submitted as a supplementary report by the Committee on Narcotics and has to deal with the ambulatory treatment of narcotic addicts in clinics.

WHEREAS: The adequate treatment of narcotic addiction necessitates constant control in addition to its medical aspect and multiple facets of social and economic factors; and

WHEREAS: The achievement of these objectives is often difficult of total attainment, even under the best regimen of therapy currently possible; and

WHEREAS: Experience has shown that treatment of narcotic addiction by means of various types of ambulatory clinic plans has been universally unsuccessful, impractical and scientifically unsound for over 50 years; and

WHEREAS: In all attempts of treatment of narcotic addiction by the ambulatory method, addiction has in fact increased; now

THEREFORE BE IT RESOLVED: That the Illinois State Medical Society voices the opinion that the ambulatory clinic plan for the treatment of narcotic addiction is inadequate and medically unsound; and

BE IT FURTHER RESOLVED: That the Illinois State Medical Society delegates to the American Medical Association be instructed to oppose the development of any such ambulatory treatment plans, and support measures designed (1) to increase research in this field; (2) to develop realistic institutional care plans for addicts; (3) to advance methods and measures toward rehabilitation of the addict and (4) to establish methods for the dissemination of factual information on narcotic addiction to the members of the medical profession.

THE PRESIDENT: Dr. Reisch, this is already a part of the supplementary report.

DR. REISCH: Yes, but it is a resolution.

THE PRESIDENT: It is referred to Committee No. 4. You will find it in the supplementary report of the chairman of the Committee on Narcotics.

Reading of Proposed Bylaw Changes

DR. WALTER C. BORNEMEIER: Gentlemen, for this report, you will need the galley sheets and the proposed changes in the Constitution and Bylaws in your packet, as well as the supplementary report.

I might also add that I have Dr. Brislen here. He is a member of this committee and, if there are any questions, he will answer all of them.

The report of the Committee on Constitution and Bylaws in the handbook on page 98 indicates that this committee has had some conflicting advice or orders, as a result of having two meetings of the House, May 1959 and December 1959, plus the Edlund Report from which to take directives.

We have followed the directives accurately whenever it was possible to do so. The Council has instructed us to follow the directives of the December, 1959 House of Delegates meeting wherever there is conflict. This we have done.

In looking over the proposed revisions of the Constitution and Bylaws, you may recognize that we have rearranged a few items into Bylaws that were suggested for the Constitution. In one instance we have reversed this procedure, but as far as we know, we have omitted nothing from the

decisions reached by this House last December. The Council has been very helpful in reviewing all of our suggestions so they conform to the wishes of the House of Delegates.

Members of this Committee will be available at the Reference Committee hearings to clarify items or answer questions. We will also be available to any member of the House who has a question covering these proposed changes. You will note that we have here covered only those subjects that have been up for discussion before. New subjects have been deliberately avoided until all the issues concerned with the survey have been implemented.

(Dr. Bornemeier then read the proposed changes in the Constitution and Bylaws, all of which appear lateer in this record in connection with the final report of this committee.)

THE PRESIDENT: These are referred to the Reference Committee which has just one object — to review the changes in the Constitution and Bylaws. They have no other subjects before them.

ANNOUNCEMENTS BY THE PRESIDENT

The Chicago caucus will be called for three minutes after the adjournment of this meeting.

The downstate caucas will be held in this room, Wednesday, at four p.m.

A very short meeting of the delegates of the Second District will be held immediately after the House has adjourned.

Before we adjourn, I would like to announce that the meeting on Wednesday of this House of Delegates will be called promptly at 8:30 a.m. It will be adjourned at 9:55 no matter where we are, so that we may have an opportunity of listening to the Harold M. Camp Memorial Lecture. This is an inauguration and I think that every member of the House of Delegates should consider it a duty to honor this very great man who, for so many years, was our Secretary. Therefore, you will have the privilege of adjourning to a certain hour. Further, the Chair will introduce the reports of such Reference Committees as are ready and which may not be time-consuming, so that you may have the opportunity of going to the Harold M. Camp Memorial Lecture.

The Chair will now entertain a motion to adjourn.

(Whereupon, at 11:20 p.m., in accordance with regular motion, the first session of the House of Delegates adjourned.)

Second Session

Wednesday, May 25, 1960

The second session of the House of Delegates of the Illinois Medical Society was convened at 8:30 a.m., Dr. Joseph T. O'Neill, President, presiding.

THE PRESIDENT: (Call to order) I will ask the Chairman of the Credentials Committee to report as to whether or not we have a quorum present.

DR. SIBILSKY: We have sufficient individuals accounted for and a sufficient number of delegates to constitute a quorum for this House of Delegates.

THE PRESIDENT: It is so ordered. The Chair will now entertain a motion that the report of the Credentials Committee will constitute the roll call of this House of Delegates. (Adopted)

THE PRESIDENT: May I have a motion as to the approval of the minutes of the previous meeting? (Adopted)

THE PRESIDENT: We have some distinguished guests in this audience whom I wish to present to you. Gentlemen of the House, I wish to present first Dr. Eugene Van Epps, the President of the State of Iowa Medical Society. Dr. Van Epps. (Applause)

I presume that he gave his all with regard to the Radiology Department yesterday and is not in good voice this morning, at least that is what he tells me.

The next gentleman is Dr. Bassett, Vice-President of the Missouri State Medical Association. (Applause)

Then we have Dr. Milton Darling, President of the Michigan State Medical Association. (Applause)

I would also like to present to you Dr. Bruce Willy, Past Chairman of the Council of the Michigan State Medical Association and, at the present time, Secretary of the Michigan State Medical Association. (Applause)

Now then, is Dr. Sorenson in the House? I know he is here because I met him last night. However, he is President of the Wisconsin State Medical Society and if he comes in later and the Chair is so informed, I will be glad to present him to you.

The next item on the agenda has to do with the selection of the meeting place for the 1963 Annual Meeting. The Chair will entertain a motion.

DR. ENGLISH: There are a lot of factors involved in a meeting place. Therefore, I would move that the Council decide where the meeting place will be unless, of course, the House wants to advise us where they want to meet.

THE PRESIDENT: A motion has been made that the Council decide where the meeting place shall be, unless the House wishes to use its own prerogatives. (Adopted)

Gentlemen, the Chairman of the Council wishes to make an announcement and present an award.

DR. MONTGOMERY: Dr. Bell, would you have Dr. Van Dellen come to the platform please?

Dr. Van Dellen has served on the Council Committee, the Medical Advisory Committee of the State Society to the Illinois Public Aid Commission since 1950. He has been a terrific help in carrying on the business of this committee.

Dr. Van Dellen, unfortunately, lives in Chicago. (Laughter) Further, the office is located in Chicago and, therefore, about three or four times a day, Dr. Van Dellen would get telephone calls for advice on how to handle certain problems that came up in connection with this Medical Advisory Committee.

Due to his many activities and work, Dr. Van Dellen has seen fit to resign as a member of this Medical Advisory Committee to the Illinois Public Aid Commission and, for that reason, the Commission wishes to award Dr. Van Dellen this citation, which I would like to read:

"Citation of Merit to Dr. T. R. Van Dellen, for outstanding services since 1950 as a member of the Illinois State Medical Society's Advisory Committee to the Illinois Public Aid Commission. He has been available at all times for guidance and counsel as the occasion arose."

This is presented by the Illinois Public Aid Commission at the 60th Annual Meeting of the Illinois State Medical Society in Chicago, May, 1960.

(Presentation and rising applause)

DR. VAN DELLEN: I would like to take this opportunity to thank the Commission for this citation. I don't think I did as much work as Monty tried to make you believe. However, it was interesting work. Further, there is just a limit as to how much time one can spend. However, once again, thank you very much for this honor. (Applause)

THE PRESIDENT: One of the Reference Committees has a question of constitutionality involved with reference to a resolution introduced by the delegate from Winnebago County, Dr. Robert Heerens and, to make it constitutional, I will ask a short resume of that resolution be read and then it can be referred back again to the Reference Committee and reported tomorrow. This is simply a question of constitutionality that was pointed out to us by the legal eagles.

I will ask Dr. William H. Schowengerdt to give you that report.

DR. SCHOWENGERDT. This is a report of Reference Committee on Constitution and Bylaws, Reference Committee No. 3.

The Constitution and Bylaws, Illinois State Medical Society, as they appear in Article XII of the amendments, state: "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any annual session, provided that such amendment shall not be acted upon before the day following that on which it is introduced."

Therefore, in considering Resolution No. 33, introduced by the Winnebago County Medical Society, it is the opinion of your committee that the proposed change must be introduced today in order to be voted upon finally tomorrow.

Therefore, your committee wishes to report as follows: In considering the changes to the Constitution and Bylaws in Chapter IX, your Reference Committee combined the recommendations of the Committee on Constitution and Bylaws and the proposed changes embodied in Resolution No. 3, brought in by the Winnebago County Medical Society, and recommends adoption of the following changes to Chapter IX.

If the members of the House of Delegates will kindly have in their hands the mimeographed proposed changes in the Constitution and Bylaws, 1960, as well as Resolution No. 33 submitted by Winnebago County, we will proceed.

If you will please turn to the bottom of page four, galley four, which reads "Chapter IX — Committees; Section 1" — delete "a Committee on Scientific Work" and substitute "a Committee to Program the Annual Meetings"; delete "and public relations" from line four to read "a Committee on Medical Service"; and add a new committee, "Committee on Public Relations," so that the change, in order of the committees as they now appear, will be as follows:

A Committee to Program the Annual Meeting.
A Committee on Medical Service.
A Medical-Legal Committee.
A Committee on Medical Education and Hospitals.
A Committee on Medical Testimony.
A Committee on Medical Benevolence.
A Grievance Committee.
A Committee on Prepayment Plans and Organizations.
A Committee on Public Relations.

Your Reference Committee recommends the approval of these changes.

I move the adoption of this portion of the report.

THE PRESIDENT: Of course, Doctor, that will have to be held over until tomorrow. However, it was thought best, in connection with parliamentary procedure to have it read today so that it would be constitutional. What you were given is simply information. It is the understanding of the Chair that this will be the case. We will, therefore, refer this matter back to your Reference Committee and you will bring it back to us in connection with your total report.

DR. SCHOWENGERDT: The next paragraph will then be, "delete Section 2 and substitute a new Section 2," which you have before you and which I will not read, inasmuch as this is being understood in this matter.

Then we also delete Section 3 and substitute a new Section, which you also have on your mimeographed form.

Then we go to the rest of that Section, which reads how the Sections are not changed.

Then we add this new Section 10: "The Committee on Public Relations shall consist of six members. Three of this committee shall be appointed by the Council for a term of three years. At the time of the initial appointment, however, terms should be staggered, with two appointed for three years, two for two years and two for one year. The committee shall prepare and submit a public relations program for the Illinois State Medical Society to the Council for approval and such a program should include public service projects of long and short duration which will increase the public's esteem for the medical profession in Illinois."

Those are the suggestions of the committee.

THE PRESIDENT: The chair shall rule that these proposals have been properly presented to the House of Delegates and may be presented for your consideration when the complete report is made.

The other night Dr. Schowengerdt, who is also Chairman of the Committee on Nursing, had a supplementary report to present and he was otherwise engaged when I called for the supplementary reports.

I should like the indulgence of the House to call your attention to the supplementary report of the Committee on Nursing. It is the intention of the Chair to ask that this be considered by the House without reference. Does that meet with your approval, Dr. Schowengerdt?

DR. SCHOWENGERDT: Your Reference Committee, in considering the report of the Committee on Nursing, has that portion of that report in their final report.

THE PRESIDENT: Then it has been officially presented today because it was not done on Monday night and we will wait until you make your report of the Reference Committee.

The next order of business is the election of emeritus members as presented by Dr. George F. Lull, Secretary.

DR. LULL: We have three emeritus members to be presented, all from the Chicago Medical Society:

Dr. Marcus H. Hobart (Evanston)
Dr. Oscar L. Lenit (Chicago)
Dr. Joseph L. Nortell (Oak Park)

THE PRESIDENT: You have heard the reading of the names of these candidates for emeritus membership. What is your pleasure? (Adopted)

DR LULL: We also have four members who are recommended for "Retired" status — all members of the Chicago Medical Society:

Dr. A. Garfield Anderson.
Dr. Jerome W. Hayden.
Dr. George E. Mueller.
Dr. Aurela Pagano.

THE PRESIDENT: You have heard the reading of the names of the candidates for "Retired" membership. What is your pleasure. (Adopted)

THE PRESIDENT: Is there any other new business to come before the House?

DR. G. E. HARTENBOWER: This resolution is from the Eye, Ear, Nose and Throat Section, and was passed yesterday.

The subject is "Prohibiting Price Advertising by Optometrists and/or Opticians in the State of Illinois or Advertising Cut-Rate Prices on Glasses."

"WHEREAS: The Section on Eye, Ear, Nose and Throat in session on May 24, 1960, has expressed its opposition to this practice, now

"THEREFORE BE IT RESOLVED: That the House of Delegates of the Illinois State Medical Society go on record as opposing the cut-rate price advertising of eye glasses in the State of Illinois."

THE PRESIDENT: That will be Resolution No. 35; assign it to Reference Committee No. 1.

Before presenting to you the reports of the Reference Committees, may the Chair call attention to the fact that at ten o'clock the first Harold M. Camp Memorial Lecture will be delivered in the Ballroom downstairs. This is in memory of this fine friend of all of us. I hope all of you will attend. Let's have a terrific attendance.

It was the intention of the Chair to ask your permission or to pose the question to you as to whether we might reconvene at eleven o'clock, following the Camp Memorial Lecture. However, the Chair has been informed that this room has been engaged for a luncheon by the Academy of General Practice and that it is not physically possible for us to do this.

Therefore, the Chair will call for some reference reports, not necessarily in order on my agenda, but some which, in my judgment, may not provoke too much controversy, so that we may get some of them out of the way so that there will not be so much business tomorrow morning.

Someone also has asked about the matter of reconvening after lunch. However, I think that constitutionally we cannot do so because the Oration in Surgery and Medicine is presented at 1:30 and it is mandatory for the President to attend and preside at the Oration.

Now then, if there is no other business to come before the House, I will call for the reports of Reference Committees.

Reference Committee on Reports of Officers, Councilors and Delegates to the AMA

Dr. George B. Callahan, Chairman

REPORT OF THE PRESIDENT

The report as published in the Handbook was accepted without any questions. The supplementary discussion was reported as an idea developed for a luncheon meeting for past-presidents, and designated "The Past-Presidents Club."

The Committee expressed its gratitude to Dr. O'Neill for a year of work well done, and his tributes to Dr. Lull and Dr. Van Dellen are noted. (Adopted)

REPORT OF THE PRESIDENT-ELECT

The report was accepted as found in the Handbook. Dr. Hesseltine appeared before the Committee. A vote of appreciation was given to the President-Elect for his duties well done. (Adopted)

REPORT OF THE SECRETARY-TREASURER

Dr. Lull's report was received. Questions were asked concerning the budget and other items of finance. Four volumes of details were made available to the Committee by Dr. Lull. These were reviewed by the members present, and satisfactory answers to the questions were found without further inquiry. Dr. Lull's report was accepted by the Committee, with commendation and appreciation for his work of this year in pinch-hitting as an interim Secretary for the welfare of the Society. (Adopted)

REPORT OF THE CHAIRMAN OF THE COUNCIL

The report as found in the Handbook is complete. Questions regarding the budget and the dissemination of financial information to the Society membership were asked by the members of the Committee and members of the Society attending the session. From Dr. Montgomery it was learned that the budget is prepared annually by the Finance Committee and submitted to the Council, and the details are available in the volumes quoted in the report of the Secretary-Treasurer.

Mr. Richards, the new Executive Administrator, was asked by the Committee for additional remarks. It is in the immediate plans of his office to submit data on expenses and a tentative budget to be submitted to the Finance Committee of the Council and then communicated to the House of Delegates for approval. Dr. Montgomery, the Chairman of the Council, concurred in these remarks.

Again our Committee accepted these reports and commended Dr. Montgomery and the Council for many jobs well done in this trying year. (Moved and seconded)

DR. MONTGOMERY: I would like to say that as requested by the members of this Reference Committee, the Finance Committee has prepared a budget which will be distributed to the House in the morning for their information and they can take action at that time.

THE PRESIDENT: You have heard the motion, which is for the approval for this portion of the report. May I say, at this time, that it is also not necessary to second these things because they have already been seconded by the signers of the report. (Adopted)

REPORT OF COUNCILORS

The reports of the Councilors were accepted in the words of the Handbook with these additions:

1. Dr. Endres of the Fourth District made additional remarks regarding county, district and state level duties with anticipated benefits from the acts of the new Executive Administrator, for whose appointment Dr. Endres commends our Council.

2. Dr. Klein of the 11th District opened his remarks by reading the first sentence of his report in the Handbook. He made the suggestion that the dates of the meetings of the Council be made known to the Society members, and to make it further known that attendance at any Council meeting by any member of the Society is welcome.

The report of the Councilor-at-Large was also accepted as found in the Handbook.

To each of the District Councilors and to our Councilor-at-Large our Committee expresses appreciation for many days and hours of strenuous effort beneficial to our Society. (Adopted)

REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

In discussion of the Social Security policy, the members of the AMA delegation confirmed that our Society has been polled in the past. It developed in the meeting that false data had been mailed recently to our Society members from an eastern survey group.

Comments were made upon the brevity of the delegates' report. However, our Committee accepted the report with gratitude.

Mr. President, I move the adoption of this portion of the report.

DR. SAXON: I would like to know if that was an honest ballot that was sent out from this Eastern thing. I understand that there were several ballots and that there was some confusion, even in our own County Medical Society.

Of course, we try not to be confused, but then, at times, we are.

Now then, relevant to this honest ballot that I am sure most of you men received, I believe this is the ballot that perhaps some of you might have signed opposing Social Security for physicians. I would like to know the status of this particular organization and their authenticity and what purpose they had for gathering this particular ballot?

THE PRESIDENT: Dr. Lull can probably enlighten us about this.

DR. LULL: When these communications were received from the "Honest Ballot Association," we had many inquiries directed to the office concerning them. We had no knowledge of the organization and so we wrote to New York, to the County Medical Society, the State Medical Society, rather, and asked them to investigate. They investigated it and wrote back that the firm making the survey had a very good reputation but they were employed by an organization of doctors which corresponded to a "Physicians Forum." They were asked by this interviewer why they had not communicated with the Illinois State Medical Society because they made it, I understand, only in the state. They were informed that they were in error — that they would communicate with us immediately. This was several weeks ago and we have not heard from them.

DR. SAXON: Just one other little item by way of comment.

Whether we know it or not, there are many subversive forces within the ranks of medicine who are sponsoring this type of information to be used for statistical purposes against organized medicine. Therefore, I think we should be on guard about what we say and what we send out or what comes to us by way of the mail. Further, if there is some question as to its authenticity, we immediately should contact the officers of our State Society or the American Medical Association for information.

I don't think we should not be alert to the possibilities of the use of these ballots.

DR. CALLAHAN: I would like to comment if I may. As far as the committee itself was concerned, it developed in the meeting that false data had recently been mailed. You will remember that there was a statement in this data that no poll had ever been had in the State of Illinois nor had it been permitted and we know, of course, that that was in error. The group there felt that was part of the false data that should be investigated in connection with having been mailed to our membership.

THE PRESIDENT: From these two comments, I am sure you are alerted as to some of the purposes that may be directed at you.

Are you ready to vote on the motion to adopt this portion of the report? (Adopted)

RE RESOLUTION NO. 20: THE SANGAMON COUNTY MEDICAL SOCIETY, APRIL 7, 1960.

This resolution is not acceptable to the Committee; instead the opinion of our Committee is that the dues should be levied commensurate with the need.

In the rather verbose and rather somewhat heated remarks made within the room at that time, the general consensus of everyone there was this—that practically everyone felt as our committee members later recorded for you in this wording, that dues should be commensurate with the work that is being done. If we are growing up into a better society, then the dues must be increased. They felt that should be done. However, if in connection with a study they felt that the current dues would carry it, then that was agreeable. Therefore, that is the reason that it was worded to the effect that dues should be levied commensurate with need because, from the conversation of most of those present, they knew that things were on the road to elevation. (Adopted)

RE RESOLUTION NO. 21: JEAN MOORE, M.D.

This resolution is not approved by our Committee because the opinions expressed at our meetings were varied

Therefore, it is recommended that no action upon it be taken. (Adopted)

DR. CALLAHAN: The reports of the President, President-Elect, Secretary-Treasurer, Chairman of the Council, and of a number of District Councilors justly paid tribute to and honored the memory of Dr. Harold M. Camp, our beloved Secretary-Treasurer. This committee commends these doctors for those tributes. We recommend that a suitable record be made of these portions of the reports and included in the House of Delegates' actions, and that a copy thereof be transmitted to the daughter of Dr. Camp, namely, Mrs. R. C. Rosine and family, 156 Walnut Street, Galesburg, Illinois. (Adopted)

Dr. Lambert F. Mammoser was not present and his place was taken by Dr. Maurice M. Hoeltgen. This report is signed by Drs. William A. Moore, Patrick H. McNulty, Clarence A. Norberg, Maurice M. Hoeltgen, and George B. Callahan, Chairman.

I move the adoption of the report as a whole.

THE PRESIDENT:

Before we take up the report of the next Reference Committee, I should like to ask the approval of the House for the action of the Council in creating the Harold M. Camp Memorial Lecture. A committee has been appointed. I don't know whether this was thoroughly covered in the report and I should like to ask House approval in concurrence of this Lectureship.

Of course, there was a great deal of discussion in Council as to what form the lecture should take. A committee was appointed and it was felt that Dr. Camp would have liked much better to have had some type of memorial delivered before the people he knew and loved rather than some sort of a medical school lectureship or something of that kind and which, in possibly a matter of five years, nobody would know what it was all about.

We felt that the perpetuity of his memory might be better served by having some function that was directly beamed at his body politic, the House of Delegates and the membership of the Illinois State Medical Society.

I would, therefore, like to entertain a motion that the House approve the action of the Council in establishing this annual Harold M. Camp Memorial Lecture. (Adopted)

Reference Committee on Reports of Constitutional Committees and Journal.

Dr. John Wolff, Chairman

COMMITTEE ON ARCHIVES

Your Reference Committee has read the report of this committee with great interest. The chairman, Dr. Tom Kirkwood, is a very young man to be concerned with the subject of archives. Your Society is indebted to him for this interest. We should cooperate with Dr. Kirkwood by asking our local county secretaries to forward news items and other matters of historical interest to our organization. He is working hand in hand with the editors of the Journal in an effort to increase interest in the preservation of the activities of the Illinois State Medical Society. Good work, Tom, and may you keep this up for a long, long time. (Adopted)

COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

The report presented in the Handbook demonstrates the excellence of the work that has been done on Medical Service. The chairman, Edwin S. Hamilton, has been exceedingly active in this program at all levels of medical organization for the past 30 years. The report tells us the step by step action taken to combat the Forand Bill. The results speak for themselves. We would also like to commend Walter Oblinger for the excellence of the Springfield News Letter. This is a must. We hope that the circulation of this newsletter will eventually be extended to every member of our Society.

Your Reference Committee looks with favor on the proposed new look in public relations. The proposed changes in our Constitution which make a separate committee on public relations, working with a Director of Public Relations, should do much to present this Society and our public with a positive approach. Your Reference Committee stands ready to support this new look, which should give us new action and good results. (Adopted)

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Although this committee did not meet, the report tells us that these gentlemen are cognizant of the many changes and progress taking place in medical education. Certainly they will keep their fingers on the pulse of these changes and will report them to us as they take place. (Adopted)

MEDICO LEGAL COMMITTEE

No report — no comment. (Adopted)

COMMITTEE ON MEDICAL BENEVOLENCE

This worthwhile function of our organization has been carried out in an exemplary fashion. The brief report does little to tell us of the tremendous good that is being accomplished.

The man behind this is a good friend of mine. He works quietly, efficiently and with a reverent attitude. Further, the contributions made by the Women's Auxiliary are also deeply appreciated. (Adopted)

GRIEVANCE COMMITTEE

This committee serves as a court of appeals to decisions of county society grievance committees. We hope that they continue to have a minimum of cases to consider such as is demonstrated in this report. This speaks well for the fact that these grievances are being settled at the local level. (Adopted)

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS

The report of this committee is a statement of the policy of this group. The committee is a necessary one in our Society as medicine is practiced today.

We suspect that most problems will be settled without reference to this committee, but we are glad that these fine intelligent individuals stand ready to serve should the occasion arise. (Adopted)

REPORTS OF THE EDITOR, EDITORIAL BOARD AND JOURNAL COMMITTEE

This Society is indeed fortunate that we have as a member one Theodore Van Dellen. Doctor Van Dellen's reputation is nationwide. His ability to write, to speak and to edit has been demonstrated over the years. He comes to us as Editor of the Journal with a million and one ideas that will eventually make our State Journal the outstanding one of the nation. This Reference Committee wholeheartedly joins with this House of Delegates in support of Doctor Van Dellen in this category. Now is the time for each of you to tell him your ideas for improving our Journal. Now is the time for each of you to express your ideas by editorials and to help in sending reports of meetings, new scientific developments and news items to him. Only by combined efforts can we make our Journal the number one Journal in the country.

As you read the recent issues of the Journal you cannot help but note the readability of the scientific articles, the excellent reference tear-out sheets, and the excellence of the editorials.

The Editorial Board and the Journal Committee certainly have been working with Ted in every way, and will continue to do so. (Adopted)

RE RESOLUTION NO. 2: KNOX COUNTY MEDICAL SOCIETY

No one appeared before your Reference Committee to speak in favor of the resolution. Your Reference Committee is well aware of this subject. This problem of polling the doctors of our state as to Social Security coverage comes up every year. Your committee unanimously asks that you disapprove this resolution. (Adopted)

RE RESOLUTIONS 4, 5, 6, 9 AND 11: KENDALL COUNTY MEDICAL SOCIETY

Doctor Saxon was present at our hearings and spoke in detail concerning these resolutions. The general tenor of these resolutions demonstrates the awareness of the positions of Kendall County to the problems of socialism, public relations and political action. This group deserves a good pat on the back. Would that all county medical societies demonstrate this interest and this ability to express them-

selves. This is the type of action that gets results. Your Reference Committee, with the approval of Dr. Saxon, has joined these five resolutions into one, which we would like to offer in the form of a special substitute resolution:

WHEREAS: Socialism in all its forms is detrimental to the health and welfare of our nation; now

THEREFORE BE IT RESOLVED: That the Illinois State Medical Society exert its influence against all forms of socialism, both medical and non-medical; and

BE IT FURTHER RESOLVED: That the Illinois State Medical Society urge its component medical societies to encourage doctors to form political action committees and to implement the financing of these committees by any legal means.

I move the adoption of this portion of the report. (Seconded)

DR. SAXON: I would like to say that I appeared before this committee and was certainly very well pleased with the essence of their report.

However, with regard to the substitute resolution, I would like to make just one brief comment.

We feel very strongly about two things in our Society. One of them is upholding very rigidly and emphasizing the code of ethics that has sponsored medicine over a period of many years.

This code of ethics, in relationship of doctors to patients, above all else, we are anxious to preserve in a dignified manner. We would not like to have medicine, on this particular plane, combine itself into a political action group. We would like to separate these two items insofar as organized medicine is concerned because we feel more than ever that the exultation and the laudable praise to be given to the high standards of medical ethics should be a thoroughly sustained item by our Society.

Covering these resolutions, I would like to have the privilege of the Chair to make a very brief comment relevant to all of our resolutions. (Approved)

DR. SAXON: In deciding the basic issues at hand, it has become apparent to the membership of the Kendall County Medical Society that we must consider first whether or not we believe in Socialism and its freedom-eroding doctrines or whether we choose to keep our freedom at any level in our government, even down to our Illinois State Medical Society.

If you are a responsible physician, well grounded in ethics and have a benevolent interest in the welfare and health of patients that you attend, even to those indigents who are unable to pay for your services, then you must oppose not only the Forand Bill but all social and welfare programs sponsored by the government, even those of our Society.

You must also oppose forceful, coercive actions of our State Society, which would also sell your freedom under a cloak of benevolence or shame you into subscribing to their form of Socialism.

How can organized medicine, with its well expired and highly principled ethics hope to attain these ethics by sponsoring irresponsible, freedom-eroding methods? Shall we suspend our ethics and moral codes in rendering medical services and become careless and irresponsible and seek methods that are selfish?

It is the dedicated purpose of our Society, now more than ever, to strengthen our moral code of ethics, to stimulate faith, courage and policies of freedom, preservation, that will give us dignity and character and freedom from fear.

Pooled and well coordinated efforts are necessary to preserve and foster the vows and principles of good medicine.

It is most unfortunate that so many of our cohorts have climbed the wagon of Socialism by subscribing to fixed fee programs for individual service for the aged, Social Security for physicians and goodness knows what all else.

Why do some of us oppose the Forand Bill and still approve Social Security for doctors of medicine, as well as fixed fees, that would be imposed upon us by those who insist that something must be done? This is something I do not know. This is an incongruity.

If you believe in opposition to Socialism, then you must, if you are acquainted with the processes, also oppose this type of thinking.

Those of you who know me well will attest to the fact that I have practiced medicine for over twenty years according to the highest ideals and principles of ethics. I have never found it necessary for anyone to impose a fixed fee on my services and I will challenge further anyone's right to my giving gratuitous service where I see this indicated. I don't have to be legislated or ruled to do this. I can assure you that my faith in the integrity of our State Society is still strong and that with proper leadership, freedom from threats of organized labor and political pressures, we can achieve the dignity and respect that we seem to be losing even in our own ranks.

I beseech you to seek truth and wisdom in your deliberations of these subjects to be presented at this meeting and in consideration of the resolutions of our Society.

On April 19th of this year, our County Medical Society sponsored a program entitled, "People and Their Freedom." Perhaps a copy of this has been distributed to you or was available to you at the back of this hall. The Oswego Community High School was the scene of this program and insofar as medicine is concerned, we pointed out the relationship of Socialism and its influence on medicine and physical health. This is a well correlated and unmistakable relationship and I would like to encourage this interest in the method of attack in all branches of organized medicine.

The resolutions submitted by the Kendall County Medical Society are contained in your Handbook. They each have a distinct but overlapping interpretation. Their meaning should be clear and merits the consideration of every physician in attendance.

There was one item that I was totally impressed with and, before the close of the meeting, I will endeavor to secure copies for all of the House members. This was a form put out by the American Farm Bureau Federation, who participated in our discussion in Kendall County, entitled, "I Believe." I think that this is a very brief, adequate interpretation of our feelings. I personally have framed a copy of this which I keep in my consultation room in Oswego and I shall certainly forever be reminded of its principles.

DR. FOWLER: Those of us who were in Washington early during the month, interviewing members of Congress, also heard a speech by the Vice-President, who said that the number one issue before the Congress was the medical care of the aged and, in this connection, I am sure that they realize the seriousness of what is going to happen to medicine. I urge you, everyone of you, to get this memorandum by writing to Mr. Joe Stetler, 535 N. Dearborn Street. It is a review of the federal statutes and court decisions relating to the political activities of medical associations and individual physicians. Each one of your presidents and secretaries of your County Medical Societies should have this and study this and know what your County Medical Society can do and what they cannot do.

In the near future we hope to find out legally whether the medical society can act as an agent to collect voluntary contributions for these various committees that are being set up. I urge you, when you go back to your homes, to form political action committees of physicians as individuals so that this Fall we can elect to Congress men who are supporters of medicine and men who will stand for our way of life.

THE PRESIDENT: Now then, are you ready for the adoption of this portion of the report? (Adopted)

RE RESOLUTION NO. 16: LAKE COUNTY MEDICAL SOCIETY

This resolution on malpractice suits suggests that a screening panel of members of the Illinois State Medical Society and the Illinois State Bar Association be formed to serve as a source of consultation for attorneys and clients prior to the filing of malpractice suits. This has been tried in other states and found wanting. It appears to serve no useful purpose. We would ask that you not approve this resolution. (Adopted)

RE RESOLUTION NO. 18: MEDICAL EXAMINING COMMITTEE

This resolution asks us to support the Department of Registration and Education in its effort to create a panel, the members of which would be competent to serve as examiners in the basic sciences and clinical subjects. This is a wholesome action, and we request the approval of this House. (Adopted)

RE RESOLUTION NO. 19: MEDICAL EXAMINING COMMITTEE

Your Reference Committee recognizes the great progress made in medical education in the past quarter of a century. There is much concern among medical educators as to the role of the medical internship. There has been a great deal of discussion and much thought given to this problem. All of us would like to increase the benefits of medical education, yet to shorten the time it takes to become a doctor. This resolution deserves considerable study. The decision on this should not be reached hastily. Therefore, we suggest that this resolution be referred to the Committee on Medical Education and Hospitals for further study. (Adopted)

Your Reference Committee is grateful to the many members of the committee. These gentlemen know how to express themselves and are not timid in doing so. However, we were able to get together at a very fine breakfast and prepare this report. Many thanks to each.

My thanks to Mrs. Zimmer and her staff for helping us prepare this report.

I now move the adoption of the report as a whole. (Adopted)

THE PRESIDENT: The Chair will now call for a formal report from the Credentials Committee, Dr. Elliott Bell.

DR. BELL: There are sixty counties represented and one hundred seventy-two delegates registered.

I move that this constitute the voting strength of this House. (Adopted)

THE PRESIDENT: I am unhappy to have to inform you that no way can be found to permit us to reconvene. The Academy of General Practice Luncheon will be in this room. They have over 200 registrations thus far. There is nowhere in the hotel where they can move.

The Chair will now entertain a motion that this House recess until nine o'clock tomorrow morning. (Moved)

DR. MIJANOVICH: In view of the great amount of work yet to be done by this House, I wonder if it would not be in order to reconvene at eight o'clock tomorrow morning instead of nine o'clock?

THE PRESIDENT: What is the will of the House?

DR. COLEMAN: I would like to move that we reconvene at eight o'clock in the morning. (Adopted)

THE PRESIDENT: I will now declare the second session to be adjourned until eight o'clock tomorrow morning.

(Whereupon, at 10 a.m., the second session adjourned.)

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Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 potients): Chemotherapy of depression – Use of meprobamate combined with benoctyzine (2-diethylaminoethyl benzilote) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. ond Carltan, H. N. (50 potients): Meprobamate and benactyzine hydrachlaride (Depral) as odjunctive theropy for patients with advonced concer. Antibiotic Med. & Clin. Therapy 6:648, Nav. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depressian with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. ond Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressians. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gardon, P. E. (50 patients): Deprol in the treatment af depressian. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial af a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Popas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Kanefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment af depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Penningtan, V. M. (135 patients): Meprabamate-benactyzine (Deprol) in the treatment af chranic brain syndrame, schizaphrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Depral in depressive conditians. Dis. Nerv. System 20:364, (Sectian One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use af Deprol (meprabamate cambined with benactyzine hydrochloride) in the affice treatment af depression. M. Ann. District af Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depressian in the elderly with a meprabamate-benactyzine hydrochlaride combinatian. Antibiatic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment af the anxiaus patient in general practice. J. Clin. & Exper. Psychapath. In press, April-June 1960.

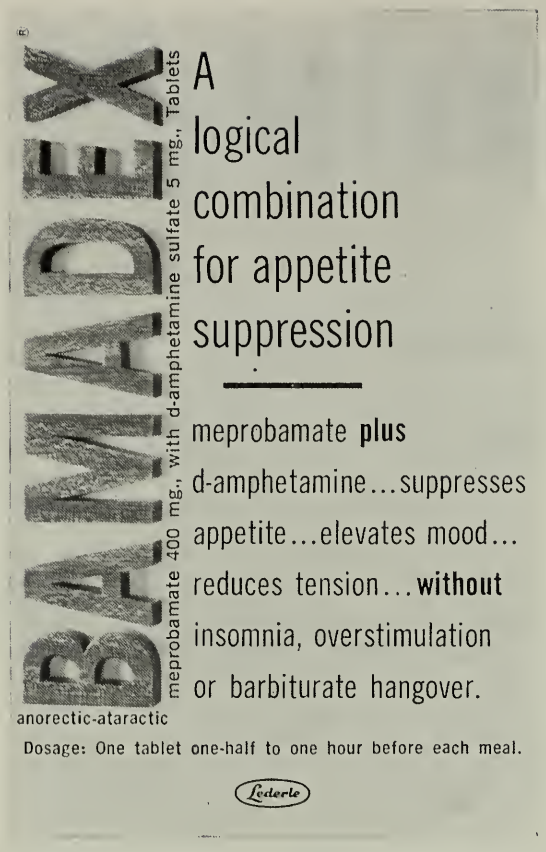
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Medical education, as conducted by educational institutions in this country, is challenged by many new and rapidly growing scientific, social, and economic forces that bear directly on the activities of the medical and allied professions, the universities, the hospitals, industry, labor, and all levels of government. The American people are convinced that adequate health services are essential in our society and are determined that "medical security" in some form shall be made available to the entire population. They are beginning to make constructive use of their wealth through voluntary as well as governmental channels to attain the fullest possible measure of benefits. These beginnings, although still far from meeting the current needs, are illustrated by the large Federal appropriations through the National Institutes of Health, the National Science Foundation, the Hill-Burton program and the annual voluntary contributions of over two billion dollars for health and welfare causes. The public is turning to the educational institutions and health professions to propose and guide such programs.

Valuable as they are, the sudden large increase in funds for investigation from a variety of sources outside the medical schools has led to a partial separation of the control, direction and utilization of research personnel from the educational institutions. One result of such outside financial support, usually temporary, is to create a group of workers with little or no responsibility for teaching or other academic services. It is apparent that a larger number of such personnel should be supported on a permanent basis to insure their continued productivity, future livelihoods and university careers. Such support would avert the danger of shifting the center of gravity in many medical schools away from their primary objectives. *From the Report of the President of the Josiah Macy, Jr. Foundation. Willard C. Rappleye, M.D. March 14, 1960.*

Head knowledge is good, but heart knowledge is indispensable. The training of the hands and feet must be added to make a rounded education. We must all learn these days to become spiritual pioneers if we would save the world from chaos.

— E. V. Hammond

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Coolidge, C. W.; Glisson, C. S., and Smith, A. S.: J.M.A. Georgia 48:167, 1959.

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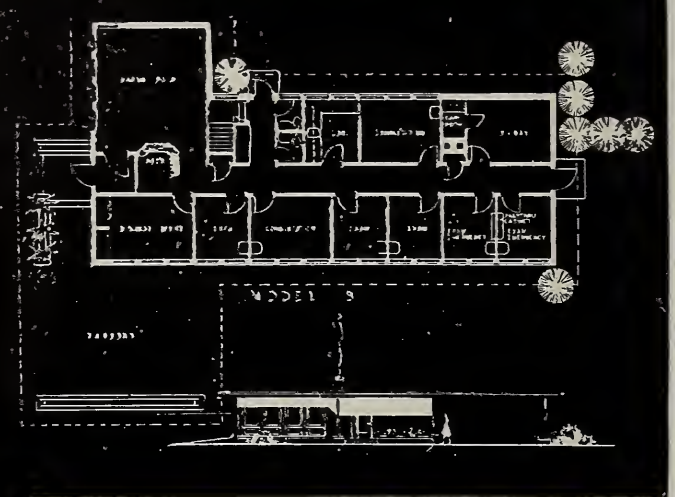
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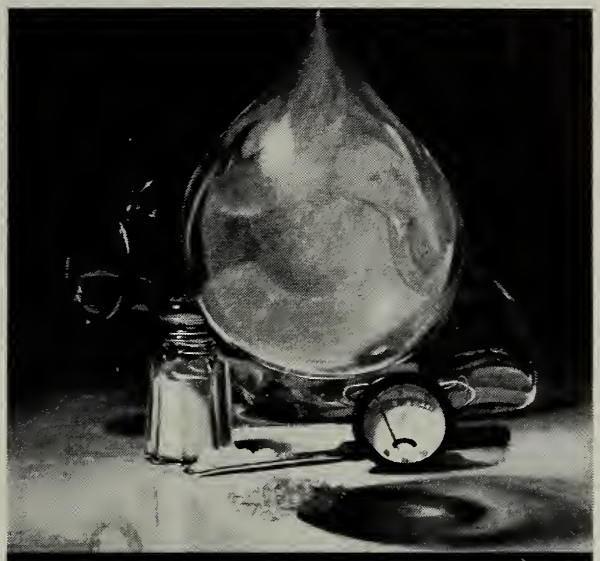
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References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Stenberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. 5:46 (Feb.) 1960. 3. Fuchs, M.; Moyer, J. H., and Newman, B.E.: Op. cit. 5:55 (Feb.) 1960. 4. Marriott, H. J. L., and Schamroth, L.: Op. cit. 5:14 (Feb.) 1960. 5. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. 21:19 (Jan.) 1960. 6. Cohen, B. M.: M. Times, to be published. 7. Breneman, G. M., and Keyes, J. W.: Henry Ford Hosp. M. Bull. 7:281 (Dec.) 1959. 8. Forsham, P. H.: Squibb Clin. Res. Notes 2:5 (Dec.) 1959. 9. Larson, E.: Op. cit. 2:10 (Dec.) 1959. 10. Kirkendall, W. M.: Op. cit. 2:11 (Dec.) 1959. 11. Yu, P. N.: Op. cit. 2:12 (Dec.) 1959. 12. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. 2:13 (Dec.) 1959. 13. Moser, M.: Op. cit. 2:13 (Dec.) 1959. 14. Kahn, A., and Greenblatt, I. J.: Op. cit. 2:15 (Dec.) 1959. 15. Grollman, A.: Monographs on Therapy 5:1 (Feb.) 1960.

'NATURETIN' IS A SQUIBB TRADEMARK.

Oral diabetic drug, an alternative

Believe me, gentlemen, the discovery of the oral antidiabetic drugs constitutes no small advance. Perhaps its full implications can be realized only by the person who actually suffers from diabetes, and who until the discovery of oral drugs faced the daily necessity of injecting a needle into some part to his body in order to lead a relatively normal life. Aside from the possible pain and apprehension arising from the need for such daily needle injections, there are the dangers of infection—no minor thing with a diabetic—the need to sterilize the needles and the skin area where injection is to be made, the necessity of following specific and detailed instructions as to storing the insulin and resuspending it preparatory to injection, the need to assure against bubbles in the fluid, the care necessary to make each injection. Some are not able to comprehend or follow the detailed instructions required for its proper use. A further disadvantage of insulin therapy is the local allergic reaction which has been reportedly produced, in varing degrees, in approximately one out of every four patients using insulin. An oral drug as an alternative to this was indeed a very welcome event. *John E. McKeen. Statement submitted to Subcommittee on Antitrust and Monopoly of the Senate Committee on the Judiciary at Hearings on Antidiabetic Drugs. April 27,* 1960.

Postpubertal cryptorchism

It has been said that the commonest cause of undescended testicle is the doctor with cold hands, for the contracted cremaster muscle of a child often holds the testis out of the scrotum for a long time, thus simulating cryptorchism, so that the diagnosis of undescended testicle (cryptorchid as distinct from ectopic testicle) is apt to be very difficult and time-consuming. With the onset of puberty, however, the enlarged testis can usually not pass into the inguinal canal (though it may still be pulled up into the superficial inguinal pouch), and the cremaster muscle becomes far less active; simulated cryptorchism is thus unlikely in the postpubertal patient. *The Undescended Testicle. Brit. Med. J. April 9, 1960.*

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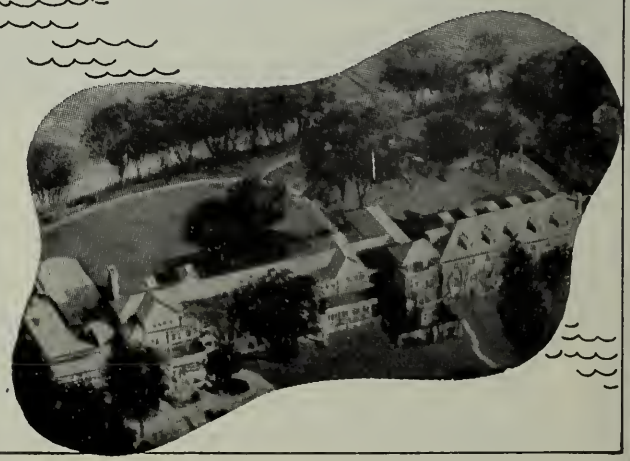
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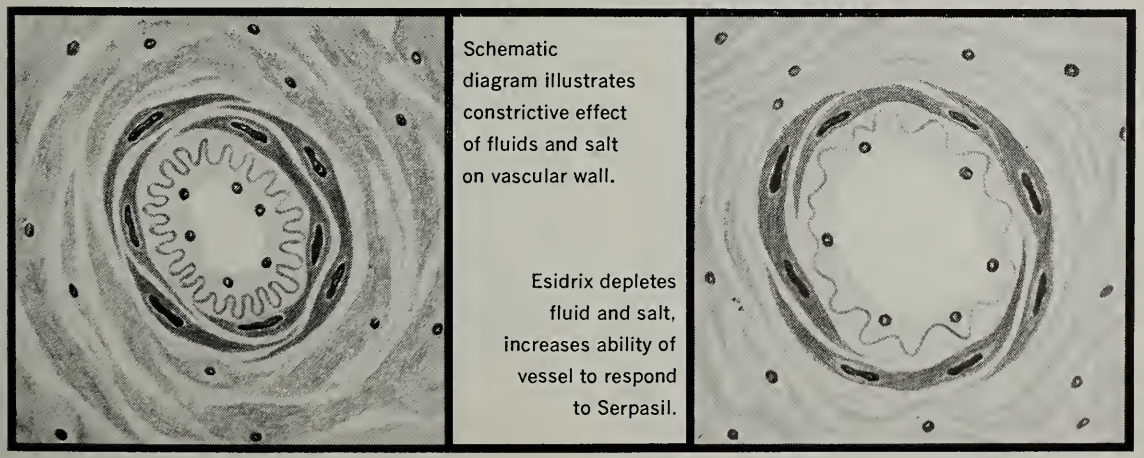
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Immunoprophylaxis

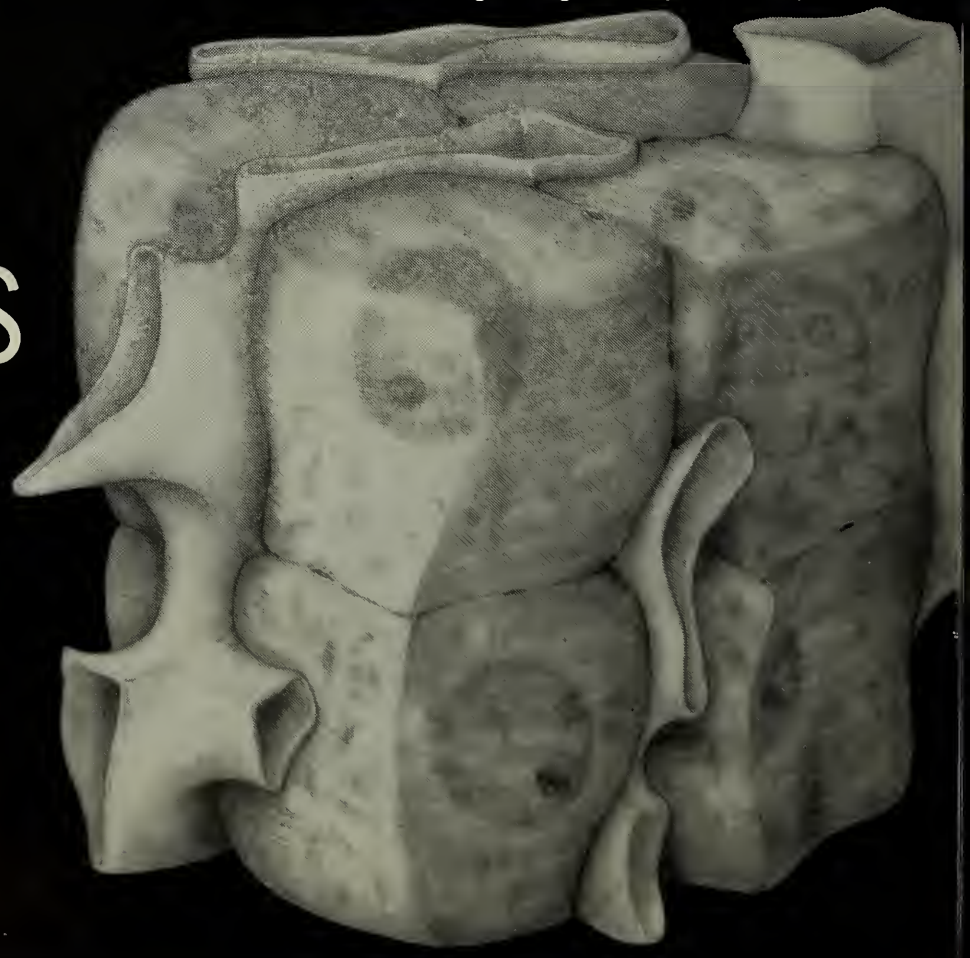
Although immunization with living microorganisms is not a new concept, great emphasis has been placed by scientists of the Soviet Union on the development of a great variety of attenuated microorganisms for use as vaccines in the immunization of man and domestic animals against numerous diseases of economic and public health importance. Tularemia, long a major problem in certain parts of the USSR, has been controlled in part by the widespread use of a living vaccine prepared from an attenuated strain of *Pasteurella tularensis*. The vaccine strain, inoculated percutaneously, is mildly reactive and markedly immunogenic. Although periodic revaccination is said to be necessary to maintain adequate immunity, it would appear that vaccines of this type are highly effective in the prevention of naturally occurring tularemia in the Soviet Union. Similarly, human beings exposed to brucellosis during the course of their occupation have been vaccinated with live, attenuated cultures of *Brucella abortus*. Resistance to infection apparently follows this immunization in a high percentage of vaccinees. Immunoprophylaxis of influenza by the use of live, attenuated influenza viruses has been practiced for several years in the Soviet Union. Multiple strains of influenza virus are required, and the vaccine is administered intranasally. Some of the reactions which have been reported following this immunization may be more severe than would be acceptable in the United States. However, further study, in this country, of nonparenteral methods of immunization with various live, attenuated viruses might prove to be worthy of more emphasis than it is currently receiving. Mumps vaccine, which is administered subcutaneously or intradermally, appears to be nonreactive and highly immunogenic. The strain of mumps virus employed in the Soviet Union has been attenuated by serial passage in embryonated eggs and successfully lyophilized. Its use on a rather extensive scale was reported recently by Smorodintsev. *F. R. McCrumb, Jr., M.D. Immunization. Ann. Int. Med. May 1960.*

The prudence of the best heads is often defeated by the tenderness of the best of hearts.

— Henry Fielding

Three-dimensional drawing showing microscopic view of hepatic cells.

what goes on in the liver?



A multitude of physiological processes . . .

The staphylococcus monster

A very superficial study of medical practice indicates the magnitude of the lag in integrating genetics with clinical practice. The problem has reached such proportions that the surgeon and physician and any moderately well-informed layman can foresee the lethal consequences of the microbial mutant epidemic. In the evolutionary world, the staphylococcal mutant is a microbial monster which is man made. This medical and evolutionary phenomenon is adequate testimony to our inability or unwillingness to grasp genetic fundamentals in therapy.

Confronted as we are now with a world-wide biogenetic epidemic, for which we are unwittingly but nevertheless morally responsible, it is obvious that many of the older therapeutic concepts that antedated the discovery of penicillin must be adapted by man to the resurging world of microbial evolution. The physician responsible for man's welfare, and possibly for his survival, must understand why this bacterial mutant emerged, and he must have an understanding of this species of the staphylococcus organism in relation to the life of man. If man is to survive on this planet, we are compelled to view the genetic phenomenon of man's evolution.

A review of the current literature on bacterial mutation and resistance by most investigators shows a regrettable tendency to confine the problem to the last decade instead of seeing this recent microbial enemy of man as still another epoch in his centuries-old struggle for survival. *Edwin J. Grace, M.D. Microbial Evolution and Antibiotic Therapy. The Journal-Lancet. May 1960.*

Study how viruses kill cancer

Some intriguing studies of cancer treatment in humans have shown that infection of cancer cells with certain viruses destroys some of the cells. The effect is temporary, since the patient soon develops antibodies against the virus. In futher studies, attempts are being made to inhibit the host's production of antibodies against these viruses, to develop methods of reaching the cancer with sufficiently powerful doses before antibodies develop, and to produce tumor-destroying properties in other human viruses. *John R. Heller, M.D. Research on Cancer Viruses. Pub. Health Rep. June 1960.*

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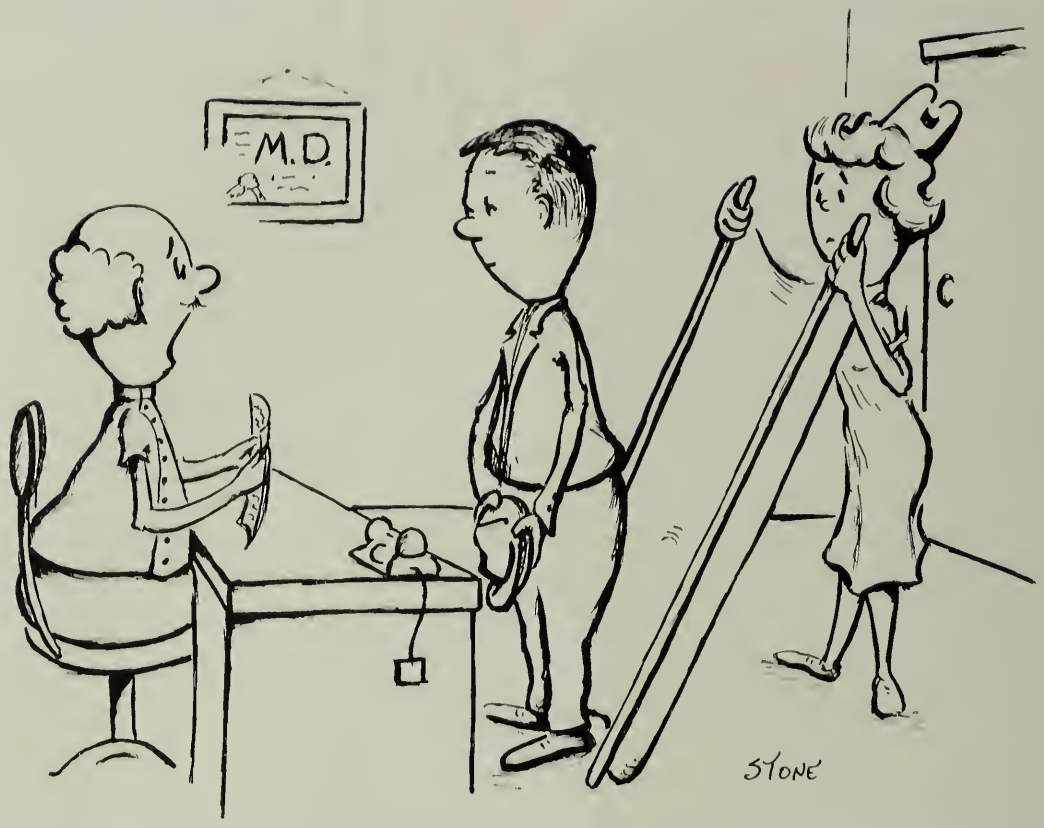
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Coffee and headaches

I believe that caffeine withdrawal headache is a real entity. One should think of the possibility of such a headache when a person is having daily morning headaches; when he volunteers that coffee is good for his headaches, or that he gets a headache when he goes without coffee; or when he gets relief from a caffeine-containing analgesic but not from aspirin. If it is decided, as therapy, to advise prolonged avoidance of caffeine, all substances containing it should be avoided—namely, coffee, tea, cola drinks, some analgesics, some rectal suppositories, and some so-called decaffeinated coffees. Because of the considerations stated above, it might be well during any therapeutic trial to eliminate chocolate, cocoa, and ergotamine as well. Finally, one has to be prepared, upon withdrawing these substances, to give some relief to the patient, as the headaches may get worse for several days. If it is feared that permanent vascular damage might result from such a severe prolonged headache, it might be preferred to carry on the withdrawal gradually in certain cases. *Joseph L. Miller, Jr., M.D. Caffeine, Chocolate and Withdrawal Headaches. Northwest Med. April 1960.*



Oh, I'm FEELING well, but the girl friends keep me a little tired.

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Tracking Ca cells in whole blood

Cytology also contributes to our general knowledge of cancer. For example, the possibility has been recognized that cancer cells may circulate in the peripheral blood of individuals for some time before metastasis occurs. But the lack of quantitative methods for detecting malignant cells in blood has hampered efforts to confirm this hypothesis and to apply the findings in further studies of metastasis and diagnostic tests. Malmgren and others at the National Cancer Institute have now reported the development of a quantitative technic for preparing human whole blood so that it can be examined cytologically.

Uses of this technic for the examination of peripheral blood obtained from a vein in the antecubital fossa of 100 patients with a diagnosis of cancer and 200 presumably well people with no evidence of cancer and no history of the disease revealed that cytologically malignant cells were identified in 39 per cent of the cancer patients and suspicious cells were present in an additional 12 per cent. In the control group, on the other hand, cells that were considered to be malignant were found in one person, or 0.5 per cent. This individual has since been found to have a very small carcinoma of the lung.

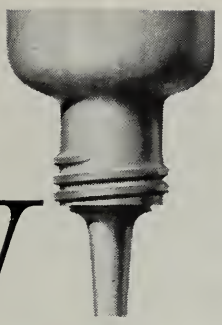
The relation of type of lesion to the presence or absence of malignant cells was not clear-cut. Malignant squamous cells appeared to exfoliate into the blood at least as often as cells from adenocarcinomas. Sarcomas exfoliated cells into the blood with about the same regularity as carcinomas. *John R. Heller, M.D. Recent Developments in Research on Cancer. Geriatrics. Jan. 1960.*

Putting it another way . . .

It should not be too difficult to point out to even the most recalcitrant patient that continued good health is much more important than the smoothest running Mercedes. The dividends from an accurate pelvic examination far exceed the finest lubrication service at the best gas station, and at about the same cost.

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We could ship the goods to the United States and let some of our employees out, if that is what would be preferred. But we want to keep our people working in the United States and not have the goods pouring in from these foreign countries. *Alvin G. Brush, American Home Products Corp. Summary of testimony before Senate Subcommittee on Antitrust and Monopoly. Jan. 27-28, 1960.*

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In skill, hygiene, and efficiency the special clinics which are now run by most hospitals have been a great advance on the old system of seeing rectal cases in general surgical outpatients; but all too often increasing efficiency generates an unwholesome conveyor-belt spirit. Clad in gaily coloured but ill-fitting dressing-gowns, patients are marched by sister into grim little cubicles, instructed to hop on a couch, and reduced into a position which can demoralise the toughest; and after an anxious wait (which might have served as Rodin's inspiration for his *Danaide*) they may find themselves impaled on a sigmoidoscope without having set eyes on the surgeon. *Haemorrhoids. The Lancet, Feb. 20, 1960.*

Abstract of Council Actions

Meeting of August 21, 1960

PRESIDENT URGES GETTING OUT THE VOTE

Dr. Hesseltine, President of the Society, cited the importance of getting out the vote on election day.

"We must oppose with force and courage the division of the population by our enemies for votes on promises for 'Pie in the Sky,'" Dr. Hesseltine said. "The endemic process before us is a disease of degenerative socialism or social corruption.

"We must prevail upon every doctor of medicine to urge his wife, all adult family members, his friends and his patients to register and to vote. This drive for votes should extend to auxiliary societies and to all those groups with whom we work."

PUBLIC RELATIONS PROGRAM OUTLINED

Dr. Heerens, Chairman of the Commmittee on Public Relations, presented a detailed program for public relations activities. Council acceptance of this report gives the committee authorization to develop a comprehensive campaign. Details of this program will be sent to county medical societies.

This will provide in part for improved communications between the ISMS and members, county societies, the press, and community, through (1) publication of a monthly newsletter to be called "The Pulse"; (2) regional meetings to discuss public relations plans; (3) staff assistance to county societies; (4) liaison with news media at the county level; (5) liaison with non-medical organizations at state and local levels to promote co-operative efforts in the solution of medical problems; and (6) aid of the Woman's Auxiliary, Student American Medical Association, and ancillary groups.

REGIONAL CONFERENCES SCHEDULED

Seven councilors announced dates for regional conferences at which staff directors will explain the expanded program of the Society and the assistance that will be available for activities at the county level. Scheduled are: District 1, Rockford, October 16; District 2, LaSalle, October 6; District 4, Peoria, September 18; District 6, Quincy, November 13; District 8, Mattoon, September 25; District 10, Steeleville, October 2; District 11, Joliet, October 30. District 3 is expected to meet in the near future and Districts 5, 7, and 9 early in 1961.

SPRINGFIELD OFFICE OPENING HITS SNAG

Dr. Reisch reported a delay in selection of new space for the Springfield office because of inability to obtain adequate quarters. Space which the Society expected to rent was given to another applicant.

AUDIT SHOWS SOCIETY IN SOUND CONDITION

Dr. Montgomery, Chairman of the Finance Committee, presented a report covering the first three months of the fiscal year. In the opinion of the auditors, who prepared the report, the Society is financially sound.

Council approved the recommendation that the fiscal year be changed to correspond with the calendar year and referred it to the Committee on Constitution and Bylaws.

INVESTMENT CHANGE NETS HIGHER RETURN

Dr. Montgomery also reported that $190,000 of noninterest bearing funds have been deposited in a savings account at the Continental Illinois National Bank at 3% interest. This was on the advice of the bank and makes the money readily available when needed during the remainder of this fiscal year.

ANNUAL MEETING SCHEDULE MODIFIED

Dr. Lorne Mason, Chairman of the Annual Meeting Program Committee, proposed changes in the arrangement for the 1961 annual meeting. Amended recommendations were approved by the Council. These provide that the House of Delegates will meet at 7:30 p.m. on Sunday, May 14, and Tuesday, May 16, and at 9 a.m., Thursday, May 18. Reference committees will meet and prepare their reports on Monday and Tuesday.

The number of subcommittees to assist the Annual Meeting Committee will be reduced to four: Banquet, with a member of the Auxiliary to serve as vice-chairman; Registration and Information; Hospitality; and Scientific Exhibits, with Dr. Coye Mason continuing as director. The work of the Local Arrangements Committee will be combined with that of the program committee.

PHYSICIANS SELECTED FOR CONFERENCE ON AGING

A report from Dr. Cannady, Chairman of the Committee on Aging, included a fine representation of physician delegates to the state meeting in Springfield, September 6-7. From these, Governor Stratton is expected to select delegates to the White House Conference.

IMPARTIAL MEDICAL TESTIMONY WINS APPROVAL

Dr. Bennett, reporting for Dr. Levinson, Chairman of the Committee on Impartial Medical Testimony, said the program has been approved by the Judicial Conference of the State of Illinois and has been referred to the Illinois Supreme Court to write a "Rule 20" to be used in the Circuit and Superior Courts of Illinois. The Supreme Court is expected to take this up in September. The committee hopes to be able to present background material.

EMERITUS AND RETIRED MEMBERS ELECTED

Council approved emeritus status for Robert T. Ewan, Galesburg. Retired status was granted to Clarence H. Schaller, Sioux Narrows, Ont., Canada; William E. Pinner, Mendota and G. L. Downie, in Africa.

The ILLINOIS Medical Journal

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Vol. 118, No. 3 **September, 1960**

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NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
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The Month in Washington



Democrats and Republicans are campaigning on opposing planks on the issue of health care for the aged. The Democratic party advocates the social security approach; the Republican party favors Federal aid in the field, but outside the social security system.

The GOP plank pledged: "Development of a health program that will provide the needy aged protection against burdensome costs of health care. Such a program should:

"—Provide the beneficiaries with the option of purchasing private health insurance — a vital distinction between our approach and Democratic proposals in that it would encourage commercial carriers and voluntary insurance organizations to continue their efforts to develop sound coverage plans for the senior population.

"—Protect the personal relationship of patient and physician.

"—Include state participation."

The key paragraph of the Democratic plank stated: "The most practicable way to provide health protection for older people is to use the contributory machinery of the social security system for insurance covering hospital bills and other high cost medical services. For those relatively few of our older people who have never been eligible for social security coverage, we shall provide corresponding benefits by appropriations from the general revenue."

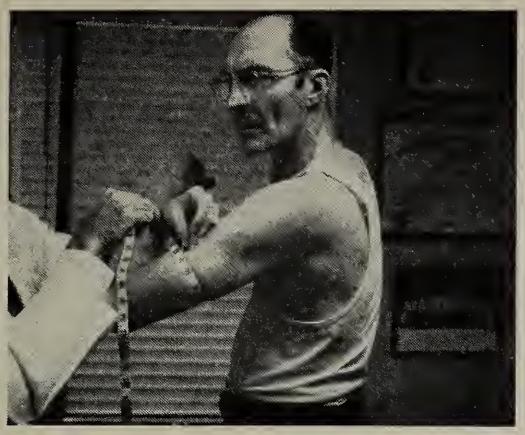
Presidential and vice presidential candidates of both parties went into the election campaigns pledged to support the health-care-for-the-aged planks adopted by their respective conventions. Vice-President Richard M. Nixon, the GOP Presidential nominee, already was on record as unalterably opposed to any program of national compulsory health insurance. The long-established position of Sen. John F. Kennedy of Massachusetts, the Democratic Presidential candidate, has been "that only by use of the social security system can we have true health insurance."

Speaking for the American Medical Association, Dr. Edward R. Annis of Miami, Fla., appeared before the platform-drafting committee of the Democratic convention at Los Angeles, and Dr. Leonard W. Larson, AMA president-elect, before the Republican policy group at Chicago.

The AMA spokesmen warned both parties that a program following the social security approach "would be unpredictably costly; it would unnecessarily cover millions of people; it would substitute service benefits for cash benefits; it would lead to poorer—not better—quality of medical care; it would overcrowd our hospitals; it would lead to the decline, if not the demise, of private health insurance; and it would interfere dangerously with the doctor-patient relationship, which is the solid foundation upon which effective medicine must be based."

Dr. Annis also urged support of the House-approved Mills plan to provide health care for the needy aged who need help with the Federal

(*Continued on page* 25)



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government and the states sharing the costs outside the social security mechanism.

In an advertisement run in some large daily newspapers in mid-August the AMA outlined its reasons for supporting the Mills plan, the ad said, in part:

"The AMA believes our nation, as well as its senior citizens, will best be served by a locally administered health aid program designed *To Help Those Who Need Help. . .*

". . . We are equally sincere in our opposition to legislative measures that approach the problem on a shotgun basis—with the idea of increasing repeatedly the social security tax in order to finance health benefits for *everyone* who is covered by the Old Age, Survivors and Disability Insurance program, regardless of their need.

"There are many serious hazards in using the social security approach to finance medical and hospital care for our older citizens. When government starts telling the doctor how to practice medicine; telling the nurses how to nurse; telling the hospital how to handle its patients, the quality of medical care is sure to decline. The cost of such a program eventually would be staggering, and would make a serious dent in the pay envelopes of millions of Americans covered by social security. Private, voluntary health insurance, which has been doing such a magnificent job, would be undermined and, in time, destroyed.

"Most important, perhaps, is the fact that such an approach would just be the beginning of compulsory, government-run medical care for every man, woman and child in the United States. For it wouldn't be long before the Federal government would be lowering the age at which people would be eligible, and adding one costly service after another to a program that would place your health care under the Federal government's thumb. And let's not forget that our present health care is recognized to be the world's finest."

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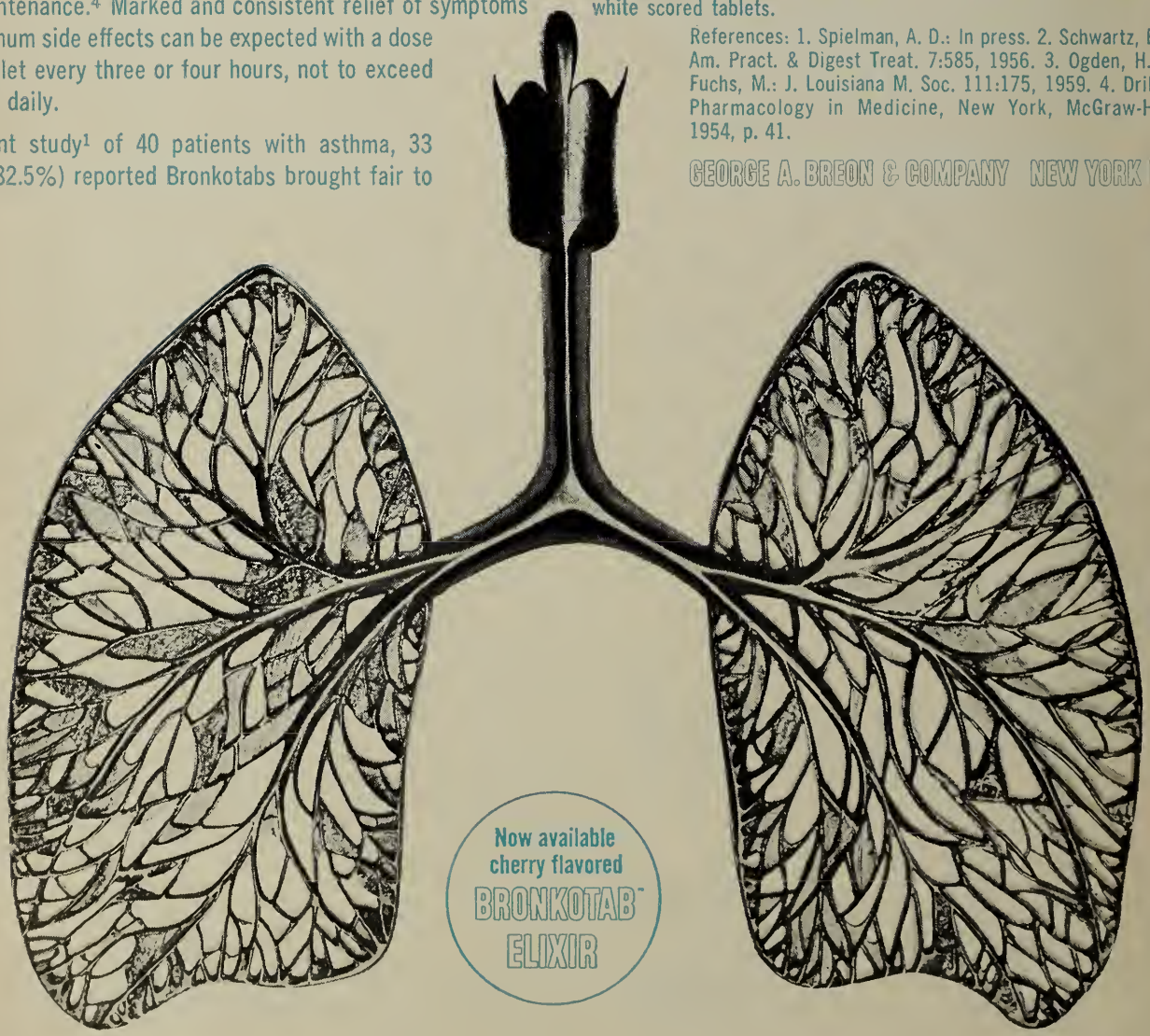
In addition, Bronkotabs decongests, using a most effective expectorant (glyceryl guaiacolate)[2] to liquefy and help expel the thick, tenacious mucus which is the cause of much of the respiratory distress in chronic asthma.[3] Since asthma is a chronic allergic disease of the bronchial tree,[3] Bronkotabs also supplies a highly efficient antihistamine (thenyldiamine) for prophylactic maintenance.[4] Marked and consistent relief of symptoms with minimum side effects can be expected with a dose of one tablet every three or four hours, not to exceed five times daily.

In a recent study[1] of 40 patients with asthma, 33 patients (82.5%) reported Bronkotabs brought fair to good relief from asthmatic symptoms. Asthma relief was pressed by ease of expectoration of secretions, reductio bronchospasm, and increased vital capacity. "The combina of drugs used in . . . [BRONKOTABS] . . . gave greater reli these patients than the conventionally used tablet [ephed theophylline, phenobarbital] . . ."

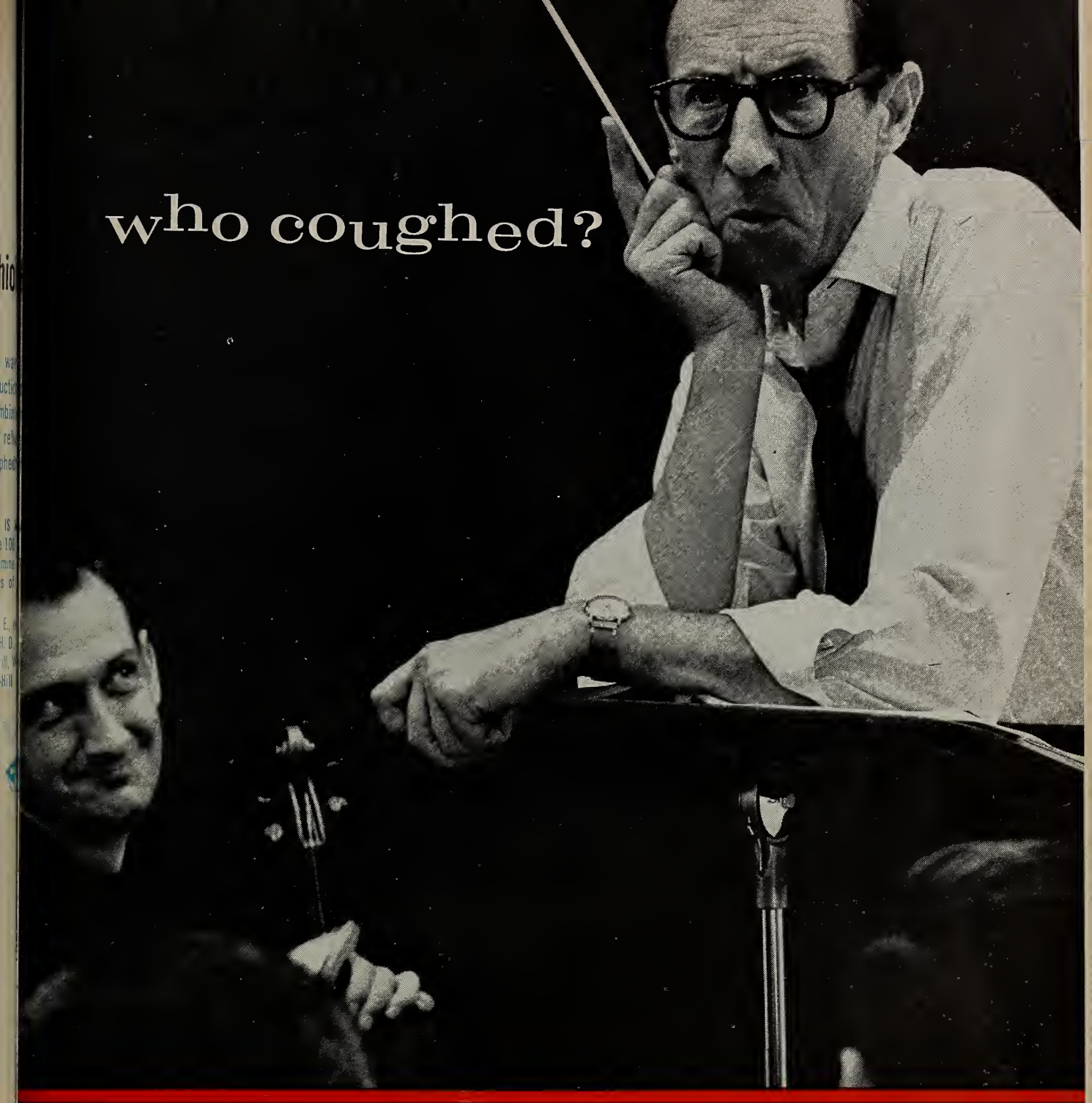
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References: 1. Spielman, A. D.: In press. 2. Schwartz, E., e Am. Pract. & Digest Treat. 7:585, 1956. 3. Ogden, H. D., Fuchs, M.: J. Louisiana M. Soc. 111:175, 1959. 4. Drill, V Pharmacology in Medicine, New York, McGraw-Hill 1954, p. 41.

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Some six to seven thousand persons in this country die each year from thermal burns. Half of these incidents occur in the very young, below four years of age, and in the old, over sixty-five. Colebrook *et al.* in 1956 reported that the frequency of burns in England and Wales was the same as it was ten years previously. Fifty per cent occurred in children. In 82 per cent of the cases the victims' clothes originally were ignited, and two thirds of all cases occurred in the home.

These British authors urge that the textile industry find ways of manufacturing fire-resistant clothing and that fabrics on the market be graded in terms of flammability. They also urge that manufacturers of kitchen utensils design those intended for hot liquids so that they cannot be easily jarred. They recommend that kitchen layouts be planned so that the stove and sink are adjacent to each other to prevent scalding accidents when hot liquids are carried from the stove to the sink.

Wallace feels that the study of the prevention of burns is not only of national but also of international importance and should be encouraged

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•

sulfonylurea failures

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"34 out of 59 sulfonylurea primary failures were successfully treated with DBI."[7]



by an authority like the World Health Organization. *Robert Turell, M.D. What's New About Thermal Burns. New York J. Med. May 1, 1960.*

To lessen fear of cancer

The malignant process can and should be defined as chronic disease with varying implications as to causation, diagnosis, course, and the results of treatment, without any attempt to varnish truth as to the seriousness of the invasive disease. It is important, also, to consider cancer as being entirely comparable to such chronic diseases as pernicious anemia, diabetes, rheumatoid arthritis with its various degrees of crippling and chronic lung or liver diseases or heart failure. All of these conditions may be fatal. However, we now have adequate control with regard to some of these diseases, thus permitting prolonged useful lives because of newer knowledge and its application. *Symposium, the Care and Preservation of the American Executive. The Bulletin of the American College of Physicians. Jan-Feb. 1960.*



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1. Walker, R. S.: Brit. M. J. 2:405, 1959.
2. Odell, W. D., et al.: A.M.A. Arch. Int. Med. 102:520, 1958.
3. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959.
4. DeLawter, D. E., et al.: J.A.M.A. 171:1786 (Nov. 28) 1959.
5. McKendry, J. B., et al.: Canad. M. A. J. 80:773, 1959.
6. Miller, E. C.: Phenformin Symposium, Houston, Feb. 1959.
7. Krall, L. P.: Applied Therapeutics 2:137, 1960.

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SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. /2830M8

Complete information available on request.



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Official Journal of The Illinois State Medical Society

SEPTEMBER, 1960
VOL. 118, No. 3

Inguinal and Femoral Hernia In the Elderly Patient

E. Lee Strohl, M.D., Willis G. Diffenbaugh, M.D., and Steven H. Nyi, M.D., *Chicago*

Many elderly patients have found the wearing of a truss a nuisance, and therefore seek surgical relief. Other aged patients have experienced incarceration on one or repeated occasions. The patient may insist on surgical repair, despite the fact that he may have other diseases of greater concern to the physician.[1]

The incidence of hernia is high in the elderly individual. Landers found it to be one in four in men over 70.[2] Means, in an Old Soldier's home with 1,417 men, with an average age of 71 years, found a 19 per cent incidence.[3]

Incarceration is increased in the elderly, as the graph (Figure 1) compiled from the statistics of Macready reveals.[4] Grace and Johnson gave a 10 per cent incidence of irreducibility in the aged.[5] The frequency of incarceration and strangulation, and the consequences of these complications are of great importance. Ferguson et al., in a study of intestinal obstructions in the aged, found 101 of 136 cases (75 per cent) of small bowel obstructions in the aged were due to external hernia.[6] Debenham found that half of 210 cases of intestinal obstruction in patients over 50 were due to external hernia.[7] Cutler found a similar incidence; 35 of 56 cases of intestinal obstruction in the aged were due to external hernia.[8]

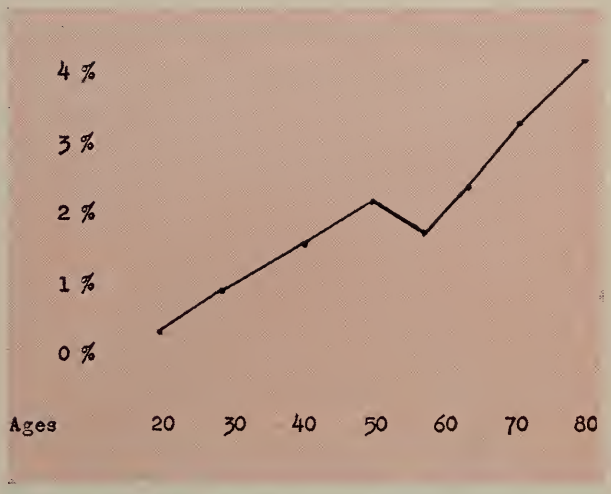


Figure 1. Percentages of irreducibility of inguinal hernia in man, according to ages in 12,686 men. *(Chart constructed from figures given by Macready, Jonathan Treatise on Ruptures. 442 pp. Chas. Griffin and Co. Ltd, London 1893)*

From the Departments of Surgery of the Presbyterian-St. Luke's Hospital and the University of Illinois College of Medicine.

The mortality rate of emergency surgery in hernia in the elderly greatly exceeds that associated with elective procedures (Table 1). Several factors account for these differences. In addition to general dehydration, deficient blood volume, and shock in an unprepared patient, are the general and local effects of acute bowel obstruction. The mortality rate has a direct relationship to age.[10] The mortality rate also is directly related to the length of time of strangulation, as shown by Requarth[18] and Laufman.[19] Procrastination in the elderly patient with an irreducible hernia is dangerous. Hernia with frequent incarceration is almost certain to strangulate at a later date.[10]

Table 1. Mortality in Emergency Operation for Strangulated Inguinal of Femoral Hernia.

Author	*Cases*	*Mortality Percent*
Bearse (1927)[9]	25	9.5
Frankau (1931)[10]	91	25.0
Brooks (1937)[11]	20	5.0
Merke (1943)[12]	53	11.3
Beck (1948)[13]	34	11.7
Strenger (1949)[14]		40.0
Sainberg (1950)[15]	69	19.9
Debenham (1953)[7]		10.0
Cutler (1956)[8]	35	51.0
Vaughan (1958)[16]	21	9.5
Jacobson (1958)[17]	52	5.7

Surgery in cardiac patient

Significant other disease, contributing to the risk of surgery, is a complicating factor in the majority of the patients of this age group. Wilcox and Clagett found that only 20.6 per cent of the patients in this age group were free of serious complicating disease.[20] La Due states that degenerative cardiovascular changes are more important than age in deciding the risks of surgery.[21] Almost all aged patients have a decreased blood volume.[22,23] In a group of aged patients having surgery, reported by Beling, adequate correction of blood volume was credited with decreasing the mortality rate from 17.4 per cent to 8 per cent.[23] The hematocrit, hemoglobin, and red cell count may give a false sense of security in that these values do not indicate accurately the circulating blood volume.

The patient with cardiovascular disease is less tolerant of complications. Atelectasis and pneumonia are frequent sequelae. Heart failure may appear suddenly and unexpectedly, under stress.[24] The aged patient may have an apparent increased tolerance to shock, because of a decreased response to shock. Moore[25] and Elman[26] have stated that such a response is to the patient's advantage, unless complications develop; if they do he frequently is unable to cope with the added insult.

Contraindications to major surgery in the patient with heart disease include infarction within three months, congestive failure, uncontrolled arrhythmia, and active myocarditis.[21] Any patient with heart disease, who has a mild to moderate limitation of activity should be digitalized prior to surgery. Adequate rest and salt restriction are necessary in patients having elective surgery. A patient with a healed myocardial infarct is more likely to have a fresh infarction than one who has not had a previous infarction.[27] The risk is not excessive, however, when operation is imperative—approximately 5 per cent, according to de Peyster et al.[28] When surgery is performed within three months after an infarction the mortality rate is high, in excess of 60 per cent.[28] The clinical findings in postoperative infarction may differ from those occurring in other infarctions. Cardiac pain may not be a prominent symptom, since the patient may be recovering from anesthesia, or be under the influence of narcotics. Unexplained hypotension, tachycardia, arrhythmia, or pulmonary edema in the early postoperative course warrants an electrocardiogram. Vowles found that nearly three-fourths of the postoperative myocardial infarctions developed on the day of operation, or within the first three days following surgery.[29] On the contrary, three-fourths of the postoperative cerebral infarctions occurred after the first postoperative week. In their series, one-third of the myocardial infarctions and two-thirds of the cerebral infarctions gave a history of hypotension.

The incidence of postoperative thromboembolism is high, especially in the patient having cardiac pathology.[28] Dehydration, like shock, is associated with a decrease in the circulating blood volume and an increase in the viscosity of the blood, both of which favor thrombosis. Anemia and inactivity also favor thromboembolism.

Fluids must be given with caution. The daily maximum should not exceed 2,000 cc. In an emergency, time must be taken to overcome dehydration and shock. The restriction of salt and

fluids parenterally in the aged patient undergoing surgery has been a great factor in the reduction of mortality.[30,31,33]

Elective surgery

Elective surgery should be done with reservations in the elderly patient with confusion, evidence of previous stroke, or marked cerebral arteriosclerosis. Frequently the mental state will deteriorate after operation, or another stroke will follow. Avoidance of undue sedation at any time in the convalescence is of great importance in the arteriosclerotic patient. Cerebrovascular accidents may occur after relatively minor procedures, or after unduly heavy sedation.

Elective repair of a hernia should not be done in the presence of excessive cough, constipation, or prostatic obstruction. The straining associated with these pathological findings favors recurrence of hernia. These pathological changes should be corrected before surgery. A clear urine, with the patient's statement that he has no urinary difficulty, should not rule out prostatic obstruction. Rectal examination of the prostate, and catheterization should be done.

Elderly patients must be seen frequently during the early post-operative period. Complications recognized in the incipient phase may be aborted. Despite all preoperative preventive measures, unexpected complications occur.

Illustrative Case: A 72 year old man entered St. Luke's Hospital with a painful incarcerated right inguinal hernia. There was a smaller, reducible left inguinal hernia. The incarcerated right inguinal hernia was repaired under local anesthesia. The bowel color returned and resection was unnecessary. Six days later he developed severe pain and incarceration of the left hernia. Under general anesthesia it was necessary to resect 18 inches of gangrenous bowel. Convalescence was complicated by pleurisy and effusion.

The incidence of wound infection may be higher than in the younger patient, due to decreased resistance and vitality of the tissues. Careful hemostasis, and minimal trauma to the tissues, are necessary requisites of the operation. Removal of the testicle and spermatic cord are advocated frequently in the elderly male to obtain a firmer closure of the inguinal canal. Removal of the cord, however, is no assurance against recurrence. Higinbotham recorded an incidence of recurrence of 11.8 per cent with removal of the cord.[32] He also stated that the incidence of infection increased in patients whose cords and testicles were removed.

The mortality rate in elective surgery in inguinal and femoral hernia in the elderly patient has been reported in the literature as 0.0 per cent to 3.8 per cent.[1,5,7,12-16,34,35]

Study of 100 cases

This report deals with 100 patients, 70 years of age or over, with inguinal or femoral hernia, who had surgical repair at Presbyterian-St. Luke's Hospital, Chicago. Eighty-five were males and fifteen females. The average age was 75.2 years; 18 were over 80 years of age, and the eldest was 99. Ninety-three patients had inguinal hernias and seven had femoral hernias. Bilateral inguinal hernia was present in 11. Ten of the inguinal hernias were recurrent, and three were incarcerated. All seven of the femoral hernias were incarcerated at the time of admission, and 26 of the inguinal hernias were incarcerated on admission.

Preoperative complicating disease was present in 73 per cent of the patients. Postoperative complications developed in 19 of the 100 patients. (Table 2) The two deaths were due to pneumonia and bowel necrosis, both patients having strangulation and bowel resection.

Table 2. Postoperative Complications following Operation for Inguinal or Femoral Hernia in 100 Patients over 70 Years of Age.

Complications	*No. of Cases*	*Mortality*
Mental confusion	4	
Urinary obstruction	3	
Wound infection	3	
Wound hematoma	1	
Bowel hemorrhage	1	
Pneumonia	1	Fatal
Bowel necrosis	1	Fatal
Pulmonary embolus	1	
Auricular fibrillation	1	
Tachycardia	1	
Exfoliative dermatitis	1	
Gout flareup	1	

General anesthesia was used in 64 of the 100 patients, procaine infiltration anesthesia in 33, and spinal in three. Bilateral repair was done in six of the 11 patients having bilateral hernias, and in three additional patients bilateral repair was staged. Bowel resection was necessary in seven of the 100 patients, six with inguinal and one femoral hernia.

Rarely do inguinal and femoral hernias occur simultaneously in elderly men. The following is an interesting example of such a case.

A man of 80 entered Presbyterian-St. Luke's Hospital. He had bilateral inguinal hernias of ten years' duration. Hypertension was a complication. At operation for intestinal obstruction a small incarcerated, Richter's type femoral hernia was found. Bowel resection was not necessary and convalescence was uneventful.

Incarceration of a hernia may occur during early convalescence from other major surgery, particularly abdominal surgery. We have had several such instances occur, for example:

An 80 year old man developed incarceration of a left inguinal hernia on the tenth postoperative day following a gastric resection. Surgery was carried out under local anesthesia, with uneventful convalescence.

The eldest patient in this series of cases was a man of 99 with an inguinal hernia that he had tolerated for 31 years. No truss had been worn in this interval. Surgery had been refused on three occasions. He entered Presbyterian-St. Luke's Hospital with incarceration, and at operation, the bowel was found to be strangulated. Eight inches of gangrenous bowel were resected. He left the hospital on the tenth postoperative day after an uneventful convalescence.

Summary

1. One hundred patients, 70 years of age or over, who underwent surgery for inguinal or femoral hernia at Presbyterian-St. Luke's Hospital are reported.

2. The incidence of incarceration is high in the elderly patient.

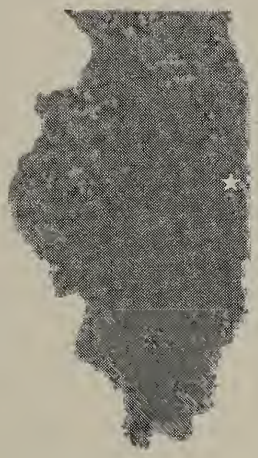
3. Death usually occurs in the strangulated hernia that requires emergency bowel resection. The mortality rate in elective surgery is low.

4. Other complicating disease is frequent and contributes to the operative risk and to the higher incidence of postoperative complications.

REFERENCES

1. Quigley, T. B.: Inguinal Hernioplasty in the Aged, N. England J. Med. 222:666-670 (Apr. 18) 1940.
2. Landers, M. B., Jr.: Age Incidence of Hernia, Indust. Med. 7:671-672 (Nov.) 1938.
3. Means, Robert L.: Management of Inguinal Hernias in the Aged, Am. J. Surg. 88:936-940 (Dec.) 1954.
4. Macready, Jonathan: Treatise on Ruptures. London, Chas. Griffin & Co., Ltd., 1893.
5. Grace, R. V., and Johnson, V. S.: Results of Herniotomy in Patients More than 50 Years of Age, Ann. Surg. 106: 347-362 (Sept.) 1937.
6. Ferguson, L. K.; Smith, Delbert C.; and Houston, P. C.: Intestinal Obstruction in the Aged, Geriatrics 4:341-352 (Nov.-Dec.) 1949.
7. Debenham, M. W., and Davis, Cooper: Inguinal Hernia in Men over 55, Geriatrics 8:403-405 (July) 1953.
8. Cutler, Condit W., Jr.: Management of Surgical Emergencies in the Aged, Bull. New York Acad. Med. 32:495-508 (July) 1956.
9. Bearse, C.: Strangulated Hernia in the Aged, Boston Med. & Surg. J. 197:471-473 (Sept.) 1927.
10. Frankau, Claude: Strangulated Hernia: A Review of Fourteen Hundred and Eighty-seven Cases, Brit. J. Surg. 19:176-191 (Oct.) 1931.
11. Brooks, Barney: Surgery in Patients of Advanced Age, Ann. Surg. 105:481-495 (Apr.) 1937.
12. Merke, F.: Des Operationsrisiko der freien Hernien jenseits des 60 Lebensjahres, Schwiez. med. Wchnschr. 73: 458 (Apr.) 1943.
13. Beck, Wm. C.: Acute Abdominal Disease in the Aged, S. Clin. North America 24:487-500 (May) 1934.
14. Strenger, George: The Surgical Treatment of Hernia in the Aged, Ann. Surg. 129:238-243 (Feb.) 1949.
15. Sainburg, F. P.: Hernia in the Aged, Am. J. Surg. 80: 60-63 (July) 1950.
16. Vaughan, Arkell M.; White, M. S.; Annan, C. M.; Coleman, J. M.; and Caserta, J. A.: Herniorrhaphy in the Aged, Am. J. Surg. 97:69-74 (Jan.) 1959.
17. Jacobson, H. A., and Beaconsfield, Peter: Emergency Surgery in the Elderly Patient, J. Am. Geriatrics Soc. 6: 657-666 (Sept.) 1958.
18. Requarth, Wm., and Theis, F. V.: Incarcerated and Strangulated Inguinal Hernia: Critical Survey of 500 Consecutive Cases, Arch. Surg. 57:267-275 (Aug.) 1948.
19. Laufman, Harold, and Daniels, J.: Clinical Factors Affecting Mortality in Strangulated Hernia, Arch. Surg. 62: 365-378 (Mar.) 1951.
20. Wilcox, L. E., and Clagett, O. T.: Surgical Procedures in Patients of Advanced Age, Proc. Staff Meet. Mayo Clin. 16:795-800 (Dec. 10) 1941.
21. LaDue, J. S.: Evaluation and Preparation of the Patient with Degenerative Cardiovascular Disease for Major Surgery, Bull. New York Acad. Med. 32:418-435 (July) 1956.
22. Bosch, D. T.; Islami, A.; Tan, O. T. C.; and Beling, C. A.: The Elderly Surgical Patient, A.M.A. Arch. Surg. 64:269-277 (Mar.) 1952.
23. Beling, C. A.; Bosch, D. T.; and Carter, O. B., Jr.: Blood Volume in Geriatric Surgery, Geriatrics 7:179-183 (May-June) 1952.
24. Lansdowne, M.; Brandfonbrener, M.; and Schock, N. W.: The Relationship of Age to Certain Measures of Performance of the Heart and Circulation, Circulation 12:567-576 (Oct.) 1955.
25. Moore, F. D., and Ball, M. R.: The Metabolic Response to Surgery. Springfield, Ill., Charles Thomas, 1952.
26. Elman, Robert: Surgical Experience in the Aged as an Aid to Surgery in the Young, J. Am. Geriatrics Soc. 3: 85-92 (Feb.) 1955.
27. Hannigan, C. A.; Wroblewski, F.; Lewis, W. H., Jr.; and LaDue, J. S.: Major Surgery in Patients with Healed Myocardial Infarction, Am. J. M. Sc. 222:628-639, 1951.
28. De Peyster, F. A.; Paul, Oglesby; and Gilchrist, R. K.: Risk of Urgent Surgery in the Presence of Myocardial Infarction and Angina Pectoris, A.M.A. Arch. Surg. 65: 448-456 (Sept.) 1952.
29. Vowles, K. D. J.; and Howard, J. M.: Myocardial and Cerebral Infarctions as Postoperative Complications, Brit. M. J. 5079:1096-1099 (May 10) 1958.
30. Ziffren, S. E.: Reduction of Operative Mortality in the Very Aged, J.A.M.A. 152:994-996 (July 11) 1953.
31. Ziffren, S. E.; Zager, L. L.; and Cullen, S. C.: Hazards of Surgery Beyond the Age of Eighty, Geriatrics 5:252-258 (Sept.-Oct.) 1950.
32. Burdick, C. G., and Higinbotham, N. L.: Division of the Spermatic Cord as an Aid in Operating on Selected Types of Inguinal Hernia, Ann. Surg. 102:849-862 (Nov.) 1935.
33. Strohl, E. Lee, and Diffenbaugh, W. G.: Abdominal Surgery in the Aged Patient, J. Am. Geriatrics Soc. 1:771-778 (Nov.) 1953.
34. Dulin, J. W.: Inguinal Hernioplasty in the Aged, J. Iowa M. Soc. 28:239-240 (June) 1938.
35. Dodd, Harold: Radical Cure of Inguinal Hernia in the Elderly, Lancet 260:1192-1196 (June 2) 1951.

Drinking and Driving



in Vermilion County

CHARLES J. SUPPLE, M.D., *Danville*

THE PURPOSE of this paper is to outline and document the program to combat drunken driving in Vermilion County.

The dangers of such driving are self-evident. The National Safety Council reports that about 30 per cent of all fatal accidents involve drinking drivers.[1] Chances of being involved in an accident are 3 to 10 times greater after more than one cocktail or one bottle of beer; thus the effect of alcohol is present whether the imbiber feels it or not.[1] Dr. Horace E. Campbell, chairman of the Colorado State Medical Society's Automotive Safety Committee, told the Conference of the American Association of Motor Vehicle Administrators last year that "alcohol is the single largest factor in our motorcar accident situation. It is equal to all other causes combined." In Montana 55 per cent of autopsy reports of deaths from vehicle accidents showed blood alcohol sufficient to impair the driving ability of the average individual. The Nassau County, N.Y., percentage was 50; in Grand Rapids, Mich., 60; in Baltimore, 52. In Buffalo chemical tests given to everyone involved in a traffic accident over a given period showed 55 per cent had been drinking. In Evanston 12 per cent of all drivers stopped at random in one week had significant amounts of alcohol in their systems.[2]

The excellent study by Haddon and Bradess in Westchester County, N.Y., showed that, in 58 of 83 fatalities (almost 70%) in single vehicle accidents, drivers had been drinking enough to impair their ability.[3] A similar study by the Delaware State Police showed 80 per cent had been drinking.[2]

Situation critical

Vermilion County's statistics are alarming. In 10 years the coroner's office has reported 209 persons killed in traffic accidents; at least 74 (over 35%) had been drinking. Records of the traffic engineering department of the State of Illinois reveal that the number of accidents in Vermilion County has increased fivefold in the last 20 years. The department of police, City of Danville, records show that during 1959, out of a total of 360 accidents, 20 drivers were booked for public intoxication and 29 for driving under the influence of alcohol. Eighteen others were to have had warrants filed against them charging that they were driving while under the influence of alcohol, but it was never done. Accidents resulting from driving under the influence of alcohol caused about $27,000 worth of property damage in Danville alone during this time, according to police estimates.[4]

Prevention may be found simply in a more stringent observation and arrest of drunken

drivers before they can become involved in an accident. In Detroit, in 10 years of chemical testing of drinking drivers, the fatal and personal injury accidents due to alcohol were reduced by 95 per cent. Indiana, pioneer of chemical testing, raised its conviction rate to 97 per cent and maintains it.[2] However, up to Sept. 1, 1959, the Vermilion County clerk's office revealed that of those arrested and charged with driving while under the influence of alcohol, only 40 per cent were found guilty. It became common knowledge that too often the drunken driver need only plead not guilty, secure the services of an able attorney, and he would never be convicted. In the last two years, since the passage of the Illinois Motor Vehicle Act, the penalty of conviction for driving under the influence of alcohol has been made severer—revocation of the driver's license for one year. Hence, the pleas of not guilty increase.

Method of attack

With these facts in mind, knowing that chemical tests are admissible in court[5] and have been upheld in Illinois,[6] the State's attorney, the county sheriff, and the author formed a program aimed to secure evidence to obtain conviction of those charged with driving under influence of alcohol and also to protect those not guilty of this offense. Our first plan was to have a physician examine each drunken driver upon his arrival at the county jail following his arrest. However, all too often a person with a high blood alcohol can fool even the most experienced observer. Therefore, blood specimens were drawn to be sent to an appropriate laboratory for the blood alcohol determination.

It was difficult to find a laboratory which would do our determinations. However, Mr. James Christensen, superintendent of the Illinois State Crime Laboratory, came to our aid. Through his cooperation, a system of sending 10 cc. tubes of oxalated blood to his department was set up. The Harger Drunkometer, owned by the county but not used for some time, was renovated and used again. A special examination form prepared by Dr. Max Apell, pathologist at Burnham City Hospital, Champaign, was filled out on each examination. This form checks motor activity, reflexes, and observations about the general behavior of the person in custody. Usually the author has been able to get each person arrested to inflate the drunkometer or to submit to a blood test. The prisoner is asked to sign an authorization permitting blood to be drawn, and usually both the drunkometer and blood level are obtained. Of those arrested, 95 per cent have agreed to one or the other test.

Accident reduction

In the ten month period, September 1959 through June 1960, 188 persons were arrested and examined. One hundred thirty six (75%) were charged with driving under the influence of alcohol; 117 were convicted, and 116 were awaiting trial. At the discretion of the examiner and State's attorney, 49 were charged with reckless driving, and of these, 49 were found guilty. Three passengers were charged with public intoxication; all were found guilty. Three others, though originally charged with driving under the influence of alcohol, were found to have negligible blood alcohol levels and were released. Even without cases that are pending, the county's conviction rate has doubled in the last six months. Also, the vehicle fatality rate for the first six months of 1960 is one-fourth what it was for the comparable period of 1959!

Summary and conclusions

Through the cooperation of the State's attorney's office, the sheriff's department, local physicians, and the Illinois State Crime Laboratory, a system hoped to be effective in curtailing the appalling rise in traffic accidents and deaths due to alcohol has been developed in Vermilion County. Although no one can keep people from going out to drink and then drive, the ability now to obtain evidence to convict these drivers, and the penalties imposed subsequent to conviction are of such nature that citizens are realizing that the risk involved in drinking and driving is too great to take.

REFERENCES

1. Traffic Safety (Chicago), 55:27 (Oct.) 1959.
2. Kearney, P.: HBD, Curse of the Road, Traffic Safety, 55:8 (Oct.) 1959.
3. Haddon, W., Jr., and Badess, V. A.: Alcohol in the Single Vehicle Accident, J.A.M.A. 169:1587 (Apr. 4) 1959.
4. Congleton, R. C.: Danville City Police Department, Danville, Ill. Personal communication to author.
5. Donigan, R. L.: Chemical Tests and the Law. Evanston, The Traffic Institute, Northwestern University, 1957, p. 17.
6. Ibid. People vs. Bobczyk, 343, Ill. p. 54.



Esophageal Perforations

COOK COUNTY HOSPITAL

MODERATOR:
Robert J. Freeark, M.D.
Director of Surgical Education, Cook County Hospital
DISCUSSANT:
John, M. Dorsey, M.D.
Professor of Surgery, Northwestern University; Chairman, Department of Surgery, Evanston Hospital

DR. ROBERT FREEARK: The esophagus comprises but a small portion of the total length of the gastrointestinal tract but contributes a great deal to the anguish and consternation of the medical profession called upon to manage its diseases. Certain anatomical and physiologic factors combine to render their management both difficult, and controversial. In the first place, in traveling some 30 cm. from the base of the tongue to the stomach, it enters three separate body areas—the neck, the chest, and the abdomen. In so doing, it picks up a somewhat precarious and highly segmental blood supply from the thyrocervical trunk in the neck, the thoracic aorta in the chest, and the inferior phrenic vessels in the upper abdomen. The segmental character of this blood supply and the relatively poor collateral within the wall of this hollow tube limit the surgeon in his efforts to mobilize, resect, and repair this structure. Furthermore, unlike the remainder of the gastrointestinal canal, the esophagus has no serosal coat from which a fibrinous seal may be elaborated to assist healing of anastomoses and repairs. Through most of its length it lacks mobile adjacent viscera to assist in walling off injured areas. Add to this its established tendency to dissolve when exposed to persistent contact with gastric acid, the high pressures to which it is subjected in such acts as belching, vomiting, and swallowing, as well as its protected and surgically inaccessible location in both the chest and abdomen, and you can appreciate why the esophagus remains the "unsolved" hollow viscus.

Among the disease processes encountered in the esophagus, one of the most difficult to diagnose and treat is perforation. Whether this results from external trauma, endoscopy, excessive pressure within the lumen or the erosion of tumors or gastric acid, the end results of treatment leave much to be desired. This is our problem and subject for today. Our guest, Dr. John Dorsey, has unique qualifications for his role as an expert in the field of esophageal disease. He is a skilled surgeon equally at "home" in the chest and abdomen. In addition, he has studiously investigated the clinical, pathologic, and laboratory aspects of esophageal disease and is the author of numerous fine articles on these subjects. His contributions to the study of the problem of esophagitis and its role in esophageal perforation has been particularly valuable and we welcome his opinions on the cases to be presented today.

In the absence of Dr. Saul Mackler of our own department of thoracic surgery, we will show a movie prepared by him which presents clinical data of three cases of spontaneous perforation of the esophagus successfully repaired at Cook County Hospital. They consti-

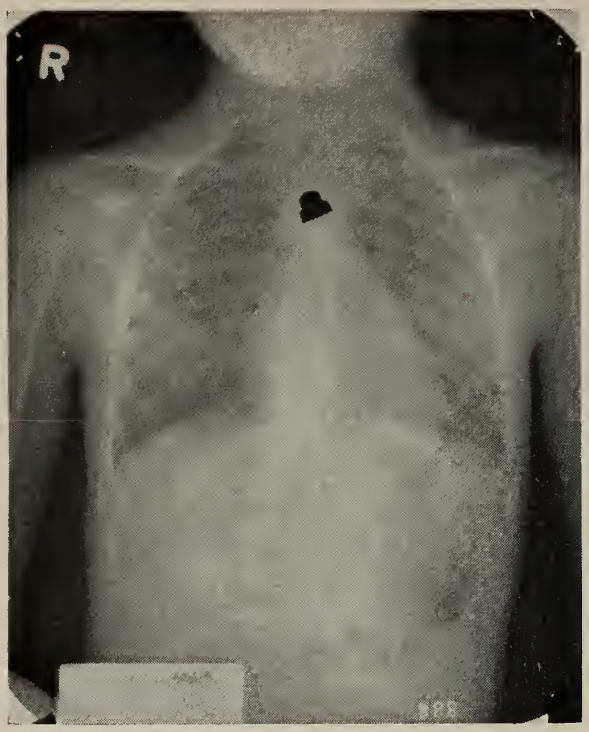


Figure 1. Foreign body lodged in the esophagus at the level of the third vertebra.

tute some of the first reported survivals following surgical closure of these perforations.

We will begin by presentation of the cases.

Case 1

Dr. John Boswick (surgical resident): This 6 year old Negro male was admitted to the hospital about six hours after swallowing a toy bell. Posteroanterior and lateral x-ray views of the chest revealed the presence of a metallic foreign body in the posterior mediastinum opposite the third thoracic vertebra (fig. 1).

Initial attempts at endoscopic removal were unsuccessful because a moderate amount of bleeding obscured the foreign body. A second attempt the next day was also unsuccessful, and following return to the ward, the child developed chest pain, fever and toxicity. Gaseous crepitation in the subcutaneous tissues of the neck was noted. Repeated x-ray films demonstrated mediastinal emphysema and no change in position of the foreign body.

Dr. Freeark: Let us stop at this point and enlist Dr. Dorsey's assistance. I'm sure you all appreciate that the child has suffered a perforation of the esophagus with escape of air and saliva into the mediastinum and tissues of the neck. In addition, a foreign body remains resolutely wedged in the lumen of the esophagus. Dr. Dorsey, be our guest.

Dr. John M. Dorsey: What occurred in this case has been clearly stated, and we can readily see that the situation is a not altogether happy one. When the second attempt at endoscopy is unsuccessful, you have little choice but to remove the foreign body by surgery. The problem then becomes one of surgical approach, and the choice rests between a thoracic and cervical route. The level of the foreign body, in this case, was opposite the third thoracic vertebra.

In general, we know that perforations of the esophagus as far down as the level of the fourth thoracic vertebrae can be effectively drained through an incision in the neck and the insertion of soft rubber drain into the posterior mediastinum (fig. 2). While this is adequate for drainage, I think it would perhaps be difficult to reach such a foreign body through an esophagotomy in the cervical area. If, in such a situation, after studying the x-rays one felt that the foreign body could be reached by this incision, it would be the one of choice as it provides drainage of the mediastinitis and avoids entering the pleural cavity. But should the level of the foreign body be a little beyond the surgeon from this approach, then we know from our approach

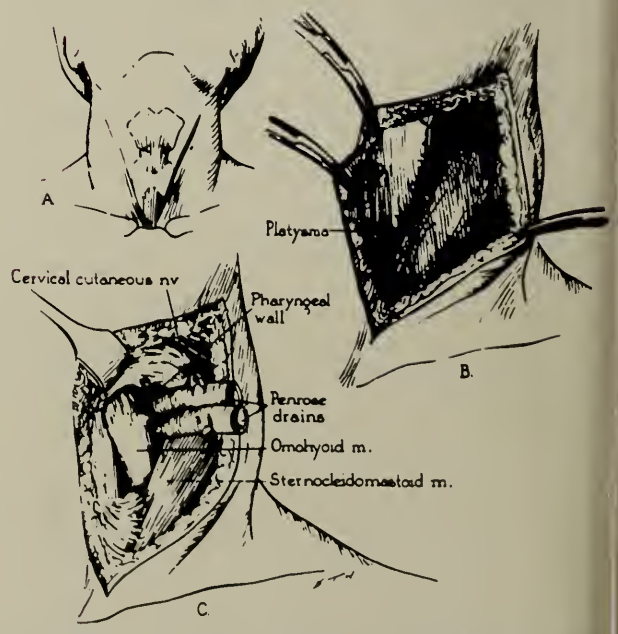


Figure 2. Surgical approach for drainage of the upper mediastinum.

to carcinoma of the esophagus that the right transthoracic approach is very effective and simple. It is easier on the surgeon than posterior mediastinotomy, though undoubtedly more difficult for the patient. I think the surgeon, depending upon the child's general condition, immediately should try to accomplish the removal by commencing in the neck. I believe this foreign body could be removed through a cervical incision. If it were lower, it could be taken out by transthoracic approach.

Dr. Freeark has provided you with a sheet (see summary and conclusions) outlining the fundamental principles of management of esophageal perforations. I agree entirely with the things he has said but would like to expand several points. In regard to endoscopic perforations, I think the role of surgical intervention is a controversial one. Certainly management with reliance upon antibiotics, parenteral feedings, and delayed surgical drainage of localized abscesses is the practice in many institutions and will suffice for many cases. The smaller wounds, especially those within the cervical esophagus, have a tendency to seal themselves. By withholding all food and discouraging swallowing, you tend to encourage this sealing process. It may be difficult to find the perforation if you do try to repair the hole.

But infection in the mediastinum or neck is not easy to control and may not respond to antibiotics unless surgical drainage is provided. In deciding upon a course of action, you have to weigh the time interval since injury, the site, size, and apparent sealing of the perforation, as well as the ability of the patient to withstand operative intervention. Most endoscopic perforations are within the cervical esophagus and can be adequately drained by neck incisions under local anesthesia. In most cases this should be done promptly. There are other instances, when we have a recognized perforation of the thoracic esophagus, and it is no different than that of an intraperitoneal viscus. Then there would be no question about immediate surgical intervention and repair. So I think we have to keep that in mind when we think of the treatment of perforation. In this case, it probably occurred in the time related to these two endoscopic procedures.

Unfortunately we sometimes think that because the signs of perforation may occur after endoscopy, and particularly after unsuccessful endoscopic examination, that it was the operator's fault. But remember that the foreign body has been present for a number of hours and that pressure necrosis may have produced perforation by itself. That has often been the mechanism of death in neglected esophageal foreign bodies.

Dr. Freeark: Would you suspect that perforation in this child was endoscopic and would it make any difference in your management?

Dr. Dorsey: I don't think it would make any difference in the management. It would be easy to perforate an inflamed and obstructed esophagus during endoscopy, but we don't have to presume that that is what happened to treat it.

Dr. Freeark: If the foreign body is impacted above the fourth thoracic vertebra, would your initial exploration always be cervical?

Dr. Dorsey: I would not say always. The foreign body will usually arrest either well above the fourth thoracic vertebra or well below it near the tracheal bifurcation. In cases such as this we might try a cervical approach and if it fails, turn the patient over and open his thorax. The point is that, even though cervical incision has been made and removal of the foreign body was not successful through it, that incision can be a valuable and effective site for drainage.

Dr. Freeark: If you encounter perforation following diagnostic esophagoscopy and there is no foreign body problem, do you treat it conservatively or use prompt surgical drainage?

Dr. Dorsey: The surgeon is often called in to see such patients after the accident has occurred, and usually a number of hours have elapsed. He seldom has to make up his mind at the onset. I do not do endoscopy myself so it never happens to me; but had I done the endoscopic procedure, I would have a pretty good idea of the size of the perforation, and that would determine what I would do next. The situation resolves itself into the old dictum: When the organism involved is relatively avirulent, any treatment works; but if it is a virulent organism, then only the most effective treatment works. That means adequate drainage, and it should be carried out usually by cervical mediastinotomy, rarely but occasionally by transthoracic approach. I should say that unless the patient shows signs of continued improvement on nonoperative management of absolutely nothing by mouth, parenteral antibiotics, and the usual supportive measures, operation should be carried out.

Dr. Freeark: How important is it to close the perforation?

Dr. Dorsey: I don't think it is important at all. If good drainage is established by an operative procedure, I don't think closure is necessary.

Dr. Freeark: The situation is, I presume, analogous to injuries of the bladder in that as long as the viscus is decompressed and provisions made for free egress of escaped contents to the outside, spontaneous healing will result.

Question: Is there a period of time beyond which you do not wish to leave a foreign body untreated?

Dr. Dorsey: It would depend on its size. I would not want to leave a large one in the esophagus very long. The smaller ones may pass, but even small ones that are sharp may perforate. I have great respect for the esophageal musculature, and even with sharp objects there will usually be some self-sealing as they escape. Remember that a large foreign body may produce pressure necrosis, and this is seldom capable of sealing itself. Remove large ones promptly.

Question: What is the role of Lipiodol® swallow in the investigation of patients with esophageal perforation or foreign body?

Dr. Dorsey: I think Lipiodol swallow is very useful. I have no objection at all to using it because, if it shows perforation, you know you have a major leak and must do something right away to provide drainage and to close the hole.

Question: If you do an endoscopy in a 6 year old child, is general anesthesia necessary? Is an endotracheal tube essential?

Dr. Dorsey: Endoscopy may be a difficult and serious procedure whether the patient is a child or adult. I had a case some time ago in which endoscopy was carried out under ideal circumstances by an expert; yet perforation occurred. The patient was not cooperative. If the patient is uncooperative, as most children are, I would prefer general anesthesia with an endotracheal tube.

I would like to show a few slides which might help to emphasize some of the points we have been discussing. We should realize that we encounter not only traumatic perforation of the normal esophagus but also certain pathologic states that may predispose to injury. Here is one I saw after several days. The patient had swallowed something, and had dysphagia; the endoscopist was not sure what he saw. The patient had some bleeding, so the scope was withdrawn and the patient returned to his room. Four days later here (fig. 3) is a mediastinal abscess. Figure 4 shows the results of a Lipiodol swallow which demonstrated prompt extravasation. This abscess was drained by a posterior mediastinotomy through the right chest, extrapleurally. That is a difficult operation and is not necessary. Transthoracic drainage at this level is just as good and much easier to do. The problem was complicated because the incision con-

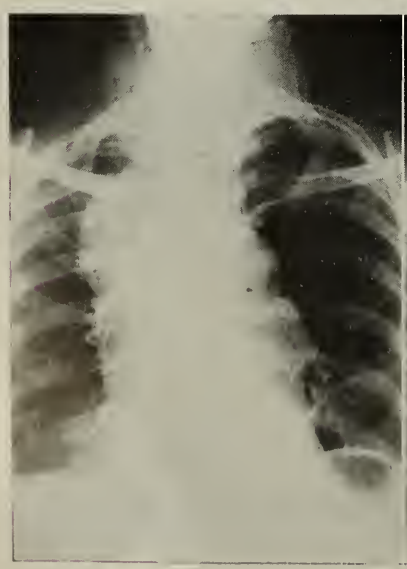


Figure 3. Mediastinal abscess following perforation of an esophageal diverticulum.

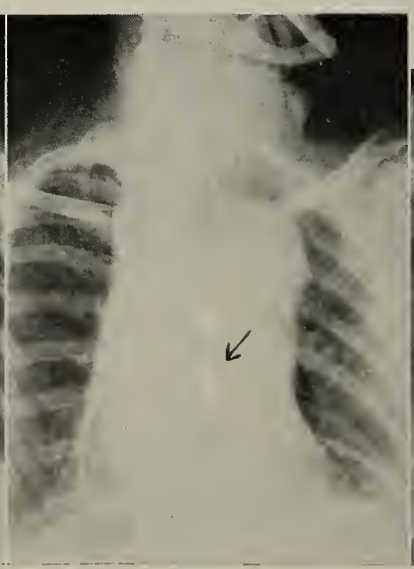


Figure 4. Lipiodol swallow in the patient with mediastinal abscess.



Figure 5. Repeat Lipiodol swallow following surgical drainage of mediastinal abscess.



Figure 6. Barium swallow in patient with esophageal stricture.



Figure 7. Lipiodol swallow in same patient following perforation by food bolus.

tinued to drain. I thought we had left a foreign body or that there was an osteomyelitis at a rib end so we gave her another Lipiodol swallow, and found this (fig. 5). The patient had an esophageal diverticulum, and the endoscopist had inadvertently passed a scope right through the bottom of it. Failure to obtain a barium swallow before endoscopy resulted in this perforation. When we recognized this, we removed the diverticulum and the wound closed. This I have seen in two cases since, and the picture is always the same: The endoscopist pushes down the scope, sees some aerolar tissue, has some bleeding because he perforated the diverticulum. Figure 2 shows a surgical approach for the removal of an esophageal diverticulum; it suffices for drainage of the cervical mediastinum. We prefer to do it on the right side. Figure 6 demonstrates another cause for perforation; this is the barium swallow of a patient who had had a stricture for many years requiring repeated dilatation. Then acute difficulties arose when a bolus of food became impacted and finally caused perforation (fig. 7). This cause was neither instrumental nor a foreign-body type. We achieved drainage by left lower mediastinotomy, which was a difficult procedure. The patient was getting along fine but on the seventh day had massive hemorrhage from perforation of the aorta and died. That is always a potential cause of death in patients with mediastinal abcess.

Dr. Freeark: For this child the cervical approach was attempted initially. The esophagus and periesophageal area showed some inflammatory changes from the perforation, although the perforation itself was not seen. The esophagus was delivered up into the cervical incision. A finger was inserted alongside the esophagus into the chest, and a foreign body could be felt but could not be delivered back into the neck for removal. An esophagotomy incision was made in the neck and a curved forcep was passed down the lumen of the esophagus, the foreign body grasped and extracted, and the incision closed. The neck was drained without establishing the location of the perforation. The child fortunately did quite well, had only moderate drainage from the incision, and the drains were removed in five days. He continued to have an uneventful course and made a successful recovery.

Case 2

Dr. William Norcross (surgical resident): This patient, a 49 year old white male, was admitted to the surgical service of the Cook County Hospital with a history of severe pain for 12 hours in the low back, lower abdomen, and costovertebral angle areas. He had experienced occasional bouts of "indigestion" for 10 or 12 years, especially following alcoholic intake, and the present episode commenced in a fashion familiar to him except for the element of back pain. He had vomited five or six times just prior to admission and had three liquid stools, and the back pain became more severe. On admission his blood pressure was 82/50 mm. Hg, pulse rate 88 per minute, and he had "grunting" respirations.

His chest was clear and the abdomen semi-rigid, with occasional bowel sounds. A Levine tube was passed and large quantities of wine colored fluid were obtained with some relief of his complaints.

The patient initially appeared improved on intravenous fluids and antibiotics. Amylase concentrations on admission were 128 units in the serum and 256 units in the urine. The normal values in our laboratory are below 32 units. He was observed for 24 hours during which time he rapidly became disoriented and irrational. On the morning of the second hospital day slight subcutaneous emphysema was detected in the tissues of the neck, and a positive Hamman's sign was noted on examination of the heart. X-rays confirmed the presence of mediastinal emphysema as well as subcutaneous emphysema, and surgery was undertaken immediately.

Dr. Freeark: Hamman's sign is the auscultatory finding of a "crunch" syncronous with each heartbeat, a characteristic of mediastinal emphysema. This x-ray (fig. 8) illustrates the problem.

I saw this man on admission. The description of the Levine return as being wine colored is very apt because it was pure muscatel. He was grossly inebriated, and the history he gave was unreliable. He was in shock and obviously had severe abdominal pain. With the picture of shock and the acute abdominal findings, the initial study of amylase determinations was made. Admission films of the abdomen were not remarkable, but the study did not include a chest x-ray. The patient was treated 12 or 18 hours for acute pancreatitis before the chest x-ray film was studied. By this time perforation of the esophagus had undoubtedly existed for perhaps as long as 18 to 24 hours.

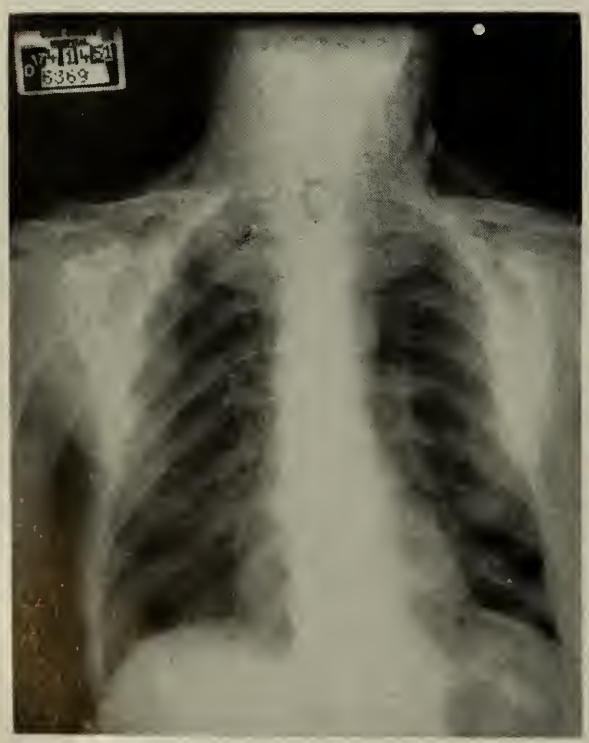


Figure 8. Perforation of the esophagus with air in the subcutaneous tissues of the neck.

Dr. Dorsey: Dr. Freeark showed me this film earlier. He did not wish to pretend that it was this patient's film. It showed some of the findings this patient could be expected to have had, and it is good for teaching purposes, but it is usually impossible to get this clear an x-ray of a patient with such a history. These individuals have terrific discomfort, and they cannot hold still because of terrific discomfort; so their x-rays are not very adequate.

One has to rely on the history and physical findings. They are rather characteristic, and it was at the Cook County Hospital that they were first well established. I remember Dr. Roger Vaughan telling years ago about these people admitted here after drinking bouts and retching who would become ill and die, and postmortem would show perforated esophagus. It was not until about 1946 that the first surgical survival took place. Dr. Mackler thereafter made a movie of the experiences here.

Patients with ruptured esophagi are difficult to categorize accurately. Perforations without endoscopy, foreign body, or external violence are said to have spontaneous perforations. These undoubtedly encompass a number of pathologically different situations. For example, we know that the esophagus may perforate following neurosurgical operations. Harvey Cushing pointed out this relationship between stimulation of the midbrain and the occurrence of erosive acid peptic esophagitis, ulceration, and eventual perforation.

Patients with the same disease rupture as a result of an incredibly high hydrostatic pressure level that develops within the lumen of the esophagus during vomiting.

The patient presented is an extremely interesting and difficult one. If we accept the fact that he has experienced a spontaneous rupture of the esophagus, what about the elevated amylase values and the history so suggestive of pancreatitis?

It is possible that his difficulties began as an acute pancreatitis following an alcoholic debauch and the repeated vomiting led to postemetic perforation. It is also possible that the amylase values were elevated by absorption of pancreatic and salivary juices that escaped into the mediastinum through the esophageal rent. Or it is possible that the amylase values represent a laboratory error.

The abdominal findings presented by this patient are not unusual in spontaneous rupture of the esophagus. The clinical picture frequently may be confused with a perforated peptic ulcer or other intra-abdominal catastrophes because of the absence of significant findings indicative of difficulties in the chest. The preservation of bowel sounds is typical of a ruptured esophagus but not of ruptured peptic ulcer.

The upper abdomen may be rigid, but most often bowel sounds can be heard. A grunting type of respirations is characteristic as is telltale crepitation in the cervical region. Early in an esophageal perforation, subcutaneous emphysema in the neck in sometimes difficult to feel. But once that finding is elicited, the suspicion would be strong that a perforated esophagus exists.

Certainly the signs of discomfort in lower esophageal perforation and in pancreatitis are similar. In some instances, severe, acute pancreatitis may produce pleural effusion. A perforated esophagus will eventually rupture the mediastinal pleura and result in the escape of esophageal contents into the chest with a similar x-ray picture of pleural effusion. However, I would feel that this man has had a perforation of the esophagus with or without pancreatitis and that treatment with thoracostomy must be done regardless of the time interval since perforation. It is surprising how often drainage of the highly irritative fluid from the chest cavity promptly improves the status of these patients.

Dr. Freeark: The patient was taken immediately to the operating room and a left posterolateral thoracotomy incision was performed in the eighth intercostal space. The overwhelming percentage of cases of spontaneous rupture occur in a characteristic site just above the diaphragm on the left side. Nearly always the rent is a longitudinal one and involves only the lower three inches of the esophagus. Some pictures taken at the time of surgery illustrate the pathology. In the first slide you can see the intact but necrotic mediastinal pleura with a characteristic blackish discoloration. A moderate amount of pleural fluid had already been aspirated but on opening this necrotic pleura, a large amount of fluid, air, and debris gushed out of the mediastinum. The esophagus was then delivered by blunt dissection into the wound; and you will note that the esophagus itself does not share in this peculiar discoloration. Here you see sutures closing a rent about one and a half inches in length in the lower end of the esophagus on the left side. The mediastinal pleura and chest cavity were irrigated, and waterseal drainage was established for the left chest. The patient was quite markedly improved immediately, but he died rather suddenly about 48 hours after surgery. Permission for autopsy could not be obtained.

Dr. Dorsey, we appreciate your remarks on the importance of diagnosis. This entity is not common. We had to go back three years to find this case; so another one is long overdue. These perforations are often missed. It takes great alertness on the part of the first doctor to examine the patient to diagnose the condition. Only then can we salvage these difficult surgical problems.

Have you seen many spontaneous perforations?

Dr. Dorsey: We reported nine last year at Evanston Hospital, a large series for a hospital of its size. These were all that were encountered since 1952. Interestingly there was surgical consultation on four and all of them survived; one was a newborn infant. That raises the question of why a newborn should have a perforated esophagus when there was no mouth-to-mouth breathing.

Dr. Freeark: Do you think peptic esophagitis is a factor in many cases of apparent spontaneous perforation?

Dr. Dorsey: I think it is an important factor. Patients with peptic esophagitis may be unaware of its presence. It is probably an important contributory factor to most perforations. I am impressed with the experimental and clinical work that implicates a pressure phenomenon in these cases. Efforts to stifle a sneeze or to stimulate vomiting may prove costly. Dr. Mackler and others have demonstrated in animals and human cadavers that when the closed esophagus is subjected to increasing pressures, the site of the rup-

ture is almost invariably in the same loeation at the lower end. Seven pounds pressure per square ineh is usually required in an adult.

If pressure alone is responsible, you would think we would see more of these eases, in view of the number of people who vomit violently.

Dr. Irving F. Stein, Jr. (attending surgeon): What about the advisability of diagnostic thoracentesis in these cases?

Dr. Dorsey: By all means. It is extremely difficult to get good x-rays in these patients, and it may be difficult to tell even with a good x-ray, the exact nature of the chest problem. Aspiration is very worthwhile. The fluid may contain food particles or, on testing with Topfers reagent, prove to contain gastric hydrochloric acid and wrap up your diagnosis.

Dr. Freeark: Several years ago we had a patient in whom diagnostic thoracentesis returned food particles and gastric acid. The patient's respiratory difficulty was not esophageal perforation, however, but a strangulated hiatus hernia in which the entire stomach was entrapped within the left chest. She too required a thoracotomy.

Dr. Dorsey: I think the important thing is to consider the possibility of spontaneous perforation in patients with abdominal pain. The characteristic triad of labored respirations with or without cyanosis, abdominal rigidity, and subcutaneous emphysema will usually be elicited if sought for. Quite characteristic in patients with postemetic rupture is pain *following* vomiting, unlike most intra-abdominal conditions which result in vomiting after the pain is established.

Dr. Freeark: We will now show Dr. Saul Maekler's movie illustrating three cases of spontaneous esophageal perforation treated at Cook County. (Movie shown at this time.)

Dr. Freeark: I think you will agree that this beautiful movie has made an excellent supplement to the fine discussion of our guest. It has been a pleasure and honor to have you with us, Dr. Dorsey.

Summary and conclusions

1. While pre-existing esophageal disease may play a role, most esophageal perforations are either *traumatic* (endoscopic, foreign bodies, penetrating chest wounds) or *hydrostatic* (postemetic, suppression of a sneeze, heavy lifting).

2. Certain local and anatomic factors permit a treacherous sequence of events following esophageal perforations. First, the escape of highly infectious oropharyngeal secretions ensues, because the relatively poor musculature and the absence of a serosal coat on the esophagus prevent spontaneous sealing. Secondly, the lack of mobile adjacent viscera and the free tissue planes of the mediastinum permit rapid spread of infectious material. In addition, the poor vascularity of the mediastinum and pleural space prevent adequate antibiotic concentrations.

3. Instrumental perforation is most frequent in the hypopharynx or upper esophagus and may occur without the awareness of the endoscopist. It should be suspected when:

(a) *During endoscopy,* brisk bleeding and loss of normal landmarks occur.

(b) *After endoscopy,* in any patient who complains of pain or dysphagia or develops a fever.

The diagnosis is usually confirmed by a chest x-ray or by palpation of air in the soft tissues of the neck. Treatment is either operative with repair and drainage or conservative with reliance on antibiotics, parenteral feedings, and delayed surgical drainage of localized abscesses.

4. Hydrostatic perforations are often called spontaneous but appear to result from sudden increases in intraesophageal pressure. They occur in the lower esophagus just above the diaphragm on the left side. They should be suspected in any patient in whom:

(a) *Pain* follows *vomiting* —regardless of whether the pain is in the chest or abdomen.

(b) The clinical picture of perforated peptic ulcer is unassociated with free air.

(c) Cervical crepitation accompanies chest or abdominal pain.

The treatment consists of emergency left thoracotomy with closure of the perforation, and drainage of the mediastinum and pleural cavity. Death may occur unless the condition is recognized.

5. The most frequent late complications of esophageal perforation is mediastinal abscess with or without empyema. Esophagocutaneous fistula, subdiaphragmatic, and cervical abscesses also occur.

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The Psychologic Impact of Cancer

Morton Bard, Ph.D., *New York*

Until recently the psychiatrist had little to do with the patient who has or has had cancer. Not many years ago the major psychological problems were keeping the patient reasonably comfortable with morphine, sedation, and deception, and reconciling the family to their inevitable loss. The long term survivor of a cancer operation was unique, and therapy was almost completely concerned with symptomatic management of the terminal cancer patient .Today, however, the major problem for the cancer patient is not that of reconciling himself to death, but rather to face the problems of living.

Our experience and that of others have shown clearly that almost all cancer patients treated adequately have some emotional difficulties. Moreover, unless these problems are solved either by the patient alone or with his family or professional help, there may be tragically unnecessary invalidism and suffering.

Pretreatment anxieties

When the symptom of cancer is first recognized, the patient immediately begins to anticipate what he believes is going to happen to him during treatment. Often this can produce such acute anxiety that the patient may delay in seeking medical intervention; on the other hand, even if medical help is sought, it may initiate a series of defensive maneuvers which would attempt to avoid therapy. Fortunately, most people are able to seek medical care and to undergo treatment. Highly individual fears and anticipations develop. For example, patients may project into the future concern about recurrence; or anticipate social rejection if mutilative surgery should be necessary; or even develop feelings of unacceptability.

Patients interviewed on the day of admission into the hospital express feelings of being trapped and helpless. Some telephone their families and request that they be taken home as a last desperate effort to thwart the dangers perceived. In a ward, they selectively perceive the experience of the other patients around them. The importance of the day of admission cannot be overemphasized. The patient experiences a reinforcement of all the fears and anticipations.

If surgery is the treatment, fears concerning anesthesia are expressed immediately before the operation. The majority of patients state that total anesthesia must be induced before they could possibly submit to surgery. Some ask that they be completely "out" even before leaving their beds to go to the operating room; others express fear of loss of consciousness. All of these feelings are indications of integrative attempts to deal with the threatening life situation and cannot be understood outside the context of the individual patient's adaptation.

Reflections of tension or panic occur immediately after admission to the hospital. Eating patterns are usually disturbed and restful sleep is impossible for most, sometimes even with sedation. Preoperative dreams, if reported, are usually of nightmare proportions, and often reflect the nature of the patient's anticipation. For example, one patient reported a dream in which she found herself in a butcher shop with female breasts extended from meat hooks all around her, although in the dream her own breasts were still intact. This patient was to have a radical mastectomy on the following day and, although she had not been informed of this probability, her anticipation is quite clear in the dream.

Postoperative depression

Postoperative reactions are sometimes even more dramatic. Horror dreams frequently occur. Physiologic reactions such as excessive perspiration and tachycardia are manifested. Most patients have difficulty in eating and report that they are unable to swallow food or that they

Presented at the First Illinois Cancer Conference March 11, 1960 *in Springfield.*

have lost their appetites. Again there are a variety of sleep disturbances, inability to fall asleep, early waking, fitful and restless sleep, and fatigue on arising. During the day some patients sit quietly, sometimes crying without participating in any ward activities, while others are overactive, often eagerly helping nurses with their work. All these comprise response to an environment which the patient perceives as hostile and injurious, and, with marked individual variations, are usually a watchful mobilization of inner resources to prevent still further injury. The patient may believe himself overwhelmed by the threat to his safety or his ability and become seriously depressed. He may be unable to make decisions and may show signs of actual disorganization. This state of mind is usually accompanied by profound feelings of dejection and a sense of helplessness, a retreat from function, and at times even suicidal thoughts. Such an anxiety-ridden patient usually turns to other people for help and loses his "independence." He seeks advice, consolation, and reassurance, and help in making decisions and in solving problems.

Depression and dependence are the reactions most generally regarded as regressive. It should be emphasized that in the vast majority of patients they are both appropriate and temporary and often are a prelude to the process of emotional repair. I cannot emphasize too strongly that these reactions should not be penalized at any time. Unless the patient has adequate help, he may not be able to solve his problems, and chronic depression, restriction of function, and pathologic dependence may persist long after hospitalization. Only rarely can he receive adequate professional help, and more often than not he is left wholly on his own to receive from friends and family what is often well-meant but inappropriate advice.

On the other hand, some patients attempt to master their difficulties by sheer force of will. This is in effect a form of denial of the limitations of their own power. When left unguided, this process may result in inappropriate solutions which can be bizarre and ineffective, or may even result in total failure and subsequent feelings of defect. As a matter of fact, the patient's enthusiastic attempts to master the situation are often closely akin to elation and are actually a thin veneer for profound depression.

The end of hospitalization heralds the beginning of convalescence. Some patients are eager to go home and feel that only then will they be able to recuperate properly. Family and friends represent the support and warmth that cannot be realized in the sterile and symbolically mutilative atmosphere of the hospital. Other patients, however, are not too eager to return home, either because of feelings of weakneses or because they feel unable to face people as yet. These patients are relating the therapeutic result to a social context and feel that even the impersonal environment is less threatening than projected fears of social unacceptability.

Impact on family relationships

Although the actual surgical experience is over, the feelings aroused by it remain active. Many patients complain that their families and friends refuse to discuss the experience so that the patient may forget. Such patients are usually resentful and feel that they would be greatly relieved if everyone would accept the fact and refer to it as they would to other experiences in life. However, other patients do not wish to discuss the experience at any time, since it may result in depression. They very quickly become hyperactive to prevent thinking about the experience and becoming "blue."

In attempting to resolve feelings about the whole experience, the support and understanding of the patient's family has an enormously significant role.

The family relationship during the illness depends upon the nature of the relationship before that illness. Where the relationship between spouses has been warm, the patient can expect continuing support and sympathy. He can receive practical help and encouragement before and after treatment, and he can expect and can accept nursing care from the spouse when he returns home. Despite impairment of earning power, he can continue to be loved. If the patient is a woman, her failure to perform household tasks as effectively as before may be expected and will be well tolerated. If advanced cancer develops, the same warmth and support can be expected, as well as suppression of the spouse's own grief with efforts to sustain the patient's morale. Such unions seem to be based on mutual affection and trust, and there are no serious economic nor sexual conflicts.

A large group of marriages are essentially "facade" marriages, with partners indifferent or ambivalent and expecting little from each other. They appear to be social and economic unions without mutual affection or trust, and none develops. In this type of marriage the patient can expect little help from the spouse, and the spouse usually is excluded or excludes himself from planning treatment or care. The patient is usually vehement in protesting his independence of the spouse or lack of need for care; truly none would seem to be forthcoming if he demanded it.

Many marital partners are frankly hostile to each other. In this case, no help may be expected from the spouse in any phase of illness, and no emotional support is offered. If advanced cancer comes or the patient becomes terminal, the spouse tries to transfer responsibility and have as little as possible to do with the patient.

At the beginning of the illness the hostile spouse may appear to be an interested one and often forces the patient into treatment. This is done not for the patient's sake, but rather to prevent further deterioration of his own position or the imposition of an unwelcome burden. The hostility soon becomes apparent, as the spouse then acts as do other hostile spouses.

If the patient has been the pivotal member of the family, the family members may need considerable help in readjusting their lives to his invalidism or to his death. Alarming symptoms may precipitate disorganizing panic related not merely to hostility but to dependency needs. In those families where the patient has been the dominant personality, even adult children may find it difficult to force on him or to urge him to accept treatment intended for his own good.

If terminal care is to be given in the home, the family may need considerable support. They should be thoroughly aware of what symptoms or events to expect. They should feel that the physician is accessible for consultations, even though these serve only as reassurance. When family members feel responsible for the health and welfare of the patient, a minor symptom may appear a major threat because of the implication that they are neglecting thier duties. If they had been ambivalent towards the patient, the implication may be particularly difficult to endure.

Even in a patient successfully treated there are numerous problems to be met as he reintegrates himself with family life. For example, his family may be aware that he has lost an important organ, and the family's own hypochondriacal notions of body injury may easily be projected on the patient, with consequent overprotection and unnecessary restrictions. The patient himself may express hostility or depression by quarrelsomeness and irritability which can seriously disrupt family relationships.

When the spouse is not available, adult children must reluctantly be relied on for nursing care. The impact on these children of nursing a sick parent may be severe if it is protracted. There may be considerable deterioration in the child's own marriage. The childen, especially the daughters, often seriously resent the restriction of their freedom which may be described as "living in a nunnery." The onset of their own "old age" is dated from the time the parent came under their care. Many children, especially those of old men who are invalided, wish that the parent had died at the time of operation, even though he is apparently cured of disease. Old women who have been cured and are invalided to some extent may be better tolerated as baby sitters or auxiliary household help. The destruction of the family pattern may even extend to the third generation; grandchildren of patients taken care of by married children may become truant or run away from home.

The patient is often aware of the disruption he is causing. The very high value we put on self-efficiency and helping others but not relying on others makes it most difficult to accept the dependent role. Restoration of a measure of independence and self-sufficiency is basic to the rehabilitation of these patients.

Anxiety may be aroused in members of the family by fear of catching cancer. This is particularly true if there has been serious change in function of the body, as with colostomy or other unusual discharge of excretions of secretions. Patients have been virtually isolated from other members of the household, even to their food being served on plates reserved for them, and are uneasily regarded as highly infectious beings.

Human ingenuity may not be capable of satisfactory solution to these problems; neverthe-

less, help can be secured from social workers experienced in dealing constructively with family groups.

Patient's levels of activity

To speak of "psychological adjustment" in the cancer patient is too indefinite. There are, instead, very many little "adjustments" to be made. Adjustment of an individual can be determined only by a careful evaluation of his present activities as compared to his activities prior to the onset of symptoms, especially in such areas as work, recreation, social functioning, and marriage. Levels of activities in these areas do not necessarily move in unison, and each can vary independently in one person.

A man who returns to work at approximately his preoperative level may restrict his social or sexual activity. Another may apparently be working full time but is regarded as a "gold brick" by co-workers. Still another shifts his employment to a job less demanding of energy. A housewife is back at housework but foregoes "heavy cleaning" and lowers her standard of cleanliness. In none of these individuals is work restriction necessarily justified by physical status. When work is restricted for other than physical reasons, two main sources can usually be identified: (1) hypochondriacal notions of body injury and fragility, and (2) fears of unacceptability to others.

What should the patient know?

Every person who deals with patients, whether doctor, nurse, social worker or clergyman, knows the importance of that "intimate and harmonious relationship" called rapport. It cannot be achieved unless there is an interchange of information. The severe threats to health, and even to life, implicit in cancer and therapy make it imperative that the patient and professional personnel reach mutually satisfactory understandings. At the same time, unfortunately, these same threats render understandings harder to achieve. The whole problem of human communication and the many anxieties about it are reflected in the perennial question "Should the patient know the truth."

Such questions, I submit, have no logical answer for they are based on the invalid assumption that there is a uniform patient, uniform cancer, and a uniform physician. There is no standard patient; people afflicted with cancer range from well-balanced individuals to overt psychotics. Cancer varies from an easily managed basal cell epithelioma with no threat of mutilation or death to a highly malignant, fatal cancer whose first clinical manifestations stem from metastases. There is certainly no physician whose ability to impart threatening information and handle anxiety can be readily predicted. Therefore, a simple rule which will cover all instances is impractical, and to seek such a rule is a waste of time.

We must then, of necessity, entertain the following question: What is the purpose of communicating information to the patient? Is it to make him a student of his own disease or to make him aware of all the threats to his health and survival? Our primary purpose, I believe, is to create in the patient a state of mind that enables him to cooperate fully with the minimum of anxiety during treatment and to resume functioning with a modicum of comfort. Any information for other ends is superfluous. Each patient, each type of disease, and the tact of the informant will set the limits on the nature and extent of information required. This is a truly pragmatic approach. It is in conflict with the notion that every patient has a moral right to know the truth. Its only justification is that it usually works.

Patients do not have easily predictable responses, like those of a piano or a typewriter. The impact of the threat of a fatal illness and mutilative surgery must be integrated into a dynamic, shifting pattern of adaptation. I do not know anyone well enough to predict with sureness his reaction to being told this kind of information. Indeed, with all of the self exploration inherent in my daily functioning, I am not at all certain about the possible nature of my own reaction. In fact, how a person has handled "stress" in the past is no guide to his present reaction. An event is distressful only when it threatens or disrupts basic patterns of adaptation, and that is dependent on the meaning of the experience to him at the time.

As we all know, communication between two human beings in a face-to-face encounter is not limited to verbal exchange. We are all aware of how a tone of voice or the circumstances in which a statement is made profoundly alters its meaning. Thus, the manner in which informa-

tion is acquired, even the setting, may be far more important than its verbal content.

The patient may seek information without ever asking about it and, indeed, may be unaware that he is seeking answers to questions. For example, any patient is very anxious to know if the doctor is capable or interested in him as a person; yet these questions are almost never asked in words. The answers are nonverbal. Information the doctor verbalizes is always mixed with those unasked but always answered questions. The patient seeks information as a guide to action. Nonverbal is just as important as verbal information. Attitudes, both positive and negative, are expressed and received in thousands of ways.

Patients generally do not want to be assaulted with information. If there is a sufficiently good relationship between the patient and those around him, he will let it be known what information he wants and how it is to be imparted to him. For example, a patient might say, "I have cancer, don't I?" But with these words is an almost imperceptible negative head-shaking which has more meaning than words, for the patient is communicating more than words.

Anxiety, which every cancer patient has, is a formidable barrier between the patient and those around him. It causes distortions, unwarranted shifts of emphasis, and inability to comprehend, to remember, or even to hear. If one wishes to be sure that a patient understands what he is told, he must first allay the disruptive anxieties. Again, he does this probably more by nonverbal than verbal means. He creates an atmosphere in which trust is possible by listening to the patient. Time spent establishing a good two-way communication pays enormous dividends later both in time and ease of management; *and the patient feels better too.*

Permit me to cite an incident which occurred at our hospital recently. The patient, a young, attractive 28 year old mother of three, and a personal friend, was in her third day following a partial thyroidectomy for a borderline malignancy with a good prognosis. I was visiting socially when her surgeon arrived during his normal rounds. With sincere interest he inquired about how she felt, and with apparent reciprocal warmth she remarked that she felt quite well except for a peculiar and annoying taste sensation in her mouth. Spontaneously, the surgeon reached into his pocket and drew forth a package of Life Savers which he offered to her. Shortly thereafter she commented on how much better she felt. Much communication had taken place during the surgeon's visit—communication of which neither the patient nor surgeon was consciously aware. The patient had indicated in her conversations with me that she was aware of her diagnosis and its implications. But her warm relationship with her surgeon obviated any necessity of direct discussion. Nevertheless, her comment about the "bad taste" was an expression of her anxiety and a veiled plea for reassurance. He responded to her need and provided symbolic gratification. The crowning significance lay in the fact that he had given her, of all things, a *Life Saver.*

I am convinced that a good relationship of warmth and mutual trust between the patient and any professional person from whom he seeks help precludes preoccupation with specific information about disease. Succinctly put, the "how" of communicating is often more important than "what" is communicated.

Summary

In conclusion, may I say that psychiatry and psychology have given little attention to the problems of the cancer survivor until recently. We are still exploring and defining, developing satisfactory formulations of events and techniques to deal with the problems. Though our studies are young, we have made progress. While we are not now and probably never will be able to give pat answers to all questions, nevertheless, certain important principles are making themselves clear, like peaks emerging from the clouds. We must be entirely realistic about the nature of cancer therapy, particularly when an organ of great psychologic significance is treated surgically. Cancer patients need warm support and understanding at every step of their experience with the illness so they may be spared intense emotional reactions and limitations in living after cure. Problems entailed in the adaptation of patients to cancer therapy, although real and immediate, are almost never insoluble. With patient and intelligent help the cancer survivor can be brought to the full enjoyment of the life saved for him, but *only* if we accept our obligation to reduce psychologic trauma and to aid in the process of restoring function.

The Present Status of Polio Vaccines*

(concluded)

MODERATOR:

Herbert Ratner, M.D., *Oak Park.*

PANELISTS:

Herald R. Cox, Sc.D., *Pearl River, N.Y.*; Bernard G. Greenberg, Ph.D., *Chapel Hill, N.C.*; Herman Kleinman, M.D., *Minneapolis*; Paul Meier, Ph.D., *Chicago.*

PART II

Vaccine safety (*Continued*)

QUESTION: How many lots were accepted as safe for licensing on manufacturer's protocol alone?

DR. HERALD COX: Not all lots were checked by laboratories other than the manufacturers'. They were random sampled. The director of the Laboratory of Biological Controls was aware of safety testing problems but was unsuccessful in obtaining a clarification from Dr. Salk.

QUESTION: Didn't the director grant the license?

DR. COX: He did not want to grant the license, but his decision was overruled.

DR. HERBERT RATNER: In March, 1954, 10 of the 48 lots of vaccine produced for field trial use were positive for live virus by tissue culture or monkey tests. In only 2 of these 10 was live virus detected by all three laboratories: that of the manufacturer, the National Institutes of Health, and Dr. Salk. In 7 of the positive lots live virus was found by a single laboratory but not by the other two.[25] As Krumbiegel pointed out at this Society's annual meeting in 1956, "The real cause for alarm was the knowledge that there was no correlation of positive test results among the different laboratories . . . and practically none within the same laboratories insofar as results of tissue culture and monkey inoculation tests were concerned . . . the results of the tests served to prove the inadequacy and unreliability of the testing procedure."[26] Notwithstanding, on the basis of Dr. Salk's report in April of no adverse effects following the vaccination of 7,507 children with commercially prepared vaccines, the 1954 field trials were allowed to proceed.

In 1955 two rather than three groups participated in safety testing: the manufacturers and the National Institutes of Health. The manufacturers ran both tissue culture and monkey tests on the vaccine they submitted for licensing. At the NIH laboratories only 14 per cent (7/50) of the lots submitted for licensing were subjected to both tests; the majority, 64 per cent (32/50), were subjected to only one test—the tissue culture test. This was done despite the fact that it was known from the 1954 testing experience that monkey tests on some trivalent material were positive even when each of their monovalent components (Types I, II, and III), before pooling, had been found negative by tissue culture tests. Twenty-two per cent (11/50) of the lots submitted for licensing were not tested by NIH at all.[28] These figures indicate that the vaccine used in 1955 was inadequately tested. Therefore, it is not surprising that there were cases of vaccine induced polio in the spring of 1955.[29]

To bring this issue of the safety of the Salk vaccine to a close, the following information is pertinent. In 1953, experienced investigators from the Michael Reese Hospital in Chicago failed to produce a safe vaccine by the Salk formula.[30] Their findings were dismissed by the backers of the Salk vaccine.[31]

In the spring of 1955 one of the manufacturers using safety tests more rigid than those required by the USPHS found live virus in its own vaccine, in another manufacturer's vaccine on the open market, and in one of Dr. Salk's vaccine preparations used as a standard for commercial vaccines.[32] This manufacturer discontinued production of Salk vaccine and did not re-

This panel discussion was edited from a transcript. Opinions presented are those of the panel members and do not necessarily represent those of the Society.

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sume until an alternative method (ultraviolet irradiation) was developed in the fall of 1955. Some of the released vaccine of this manufacturer, however, had already been used in Massachusetts, which experienced an epidemic, and some of the same lots were used in New York, and in Minnesota, where, as Dr. Kleinman has said, he found 83 per cent effectiveness.[33] Of course, many of us thought the effectiveness of the 1955 vaccine was due primarily to the fact that it did contain live virus.

One other manufacturer found live virus in another of Dr. Salk's standard vaccines.[34] A member of the USPHS also found live virus in commercial vaccine other than that admitted by the USPHS to have induced cases.[35] The findings were not published. The Massachusetts State Polio Advisory Committee, which included among others, John F. Enders, Thomas H. Weller, and Maxwell Finland, temporarily banned the vaccine despite USPHS licensing because of its knowledge of these findings.[36] Epidemiologic evidence of unsafe vaccine from manufacturers not named by the USPHS has been reported by Anderson,[37] Redeker,[38] and others.[39]

It should also be stressed that safety testing was inadequate when Dr. Salk developed his vaccine and when the vaccine was commercially prepared for the field trials of 1954 and for licensing and use in 1955. The claim of long duration of effectiveness, then, as measured by antibody levels reported by Salk[40], Brown[41], and others[42], really applies to a vaccine which did not exclude the presence of live virus. It does not apply to current vaccine in which potency has been sacrificed for safety. There is internal evidence in the papers of Salk and Brown that some of the antibody response to the vaccine was too pronounced to be explained by a killed virus.[43]

At present, epidemiologic methods employed by the USPHS to assure safety of the vaccine are inadequate: first, because of the failure to thoroughly survey untoward reactions,[44] and, secondly, because of unrefined criteria for the determination of safety; for instance, insistence on correlation of initial paralysis at the site of inoculation,[45] and discontinued reporting of satellite cases.[46]

QUESTION: Has any state health department recommended that Salk vaccine not be used?

DR. RATNER: I know of no state health department that refuses to issue it now, although earlier this was not the case. This is a question of whether a state health department is in a position to oppose mass propaganda and the public opinion that has been formed by it.

DR. HERMAN KLEINMAN: There is only one thing we can do in Minnesota and that we are doing. There is no known way of preventing polio with a licensed product at the present time except through the use of the Salk vaccine. While I am an agnostic about the effectiveness of the Salk vaccine, I still believe it does something in preventing paralysis. So we owe it to the public to recommend its use. On the other hand, if we are going to act not only as public health physicians but as scientists, we must continue our investigations into the truth about the Salk vaccine. On the basis of the facts as I know them, we must look for something better.

DR. PAUL MEIER: It seems to me that the state and local health officers are at levels different from USPHS and in much the same position as my children's pediatrician. He said, "We are very disappointed in the Salk vaccine; we are very unhappy with it; but what can we do? The people who have the evidence, who have the knowledge, who should be able to judge, say use it. I am in no position to second guess them and to make a different decision. I have to recommend it and I have to use it."

This is no position for public health officers to be in, but there isn't any question that *is* the position. All the facts have never been discussed. The great pressure of publicity has been exerted. It would be a health officer with great self-confidence who would say that on the basis of the little he knows he is prepared to make a judgment different from that of the USPHS and to decide not to give it. On the other hand, I don't consider it convincing evidence of the efficacy of Salk vaccine that all, or almost all, health officers have gone along with it.

DR. BERNARD GREENBERG: I would like to second that comment to make sure that my position is understood. I'm an agnostic like Dr. Kleinman. I am sorry that I do not know what the effectiveness of the Salk vaccine is. Since nothing else is available, there seems to be no alternative but to push the use of it. I don't think we should do so in ignorance, nor too complacently, believing that as long as we have

something partially effective there is no need to have something better. The USPHS is, in effect, saying, "Let's face it: we were burned the last time by getting into this business too quickly; so this time we are going to be more cautious." By being more cautions, we may make a mistake by accepting a better polio vaccine too slowly. And that's what I am trying to emphasize: They must realize they are making this mistake possible. The issue must be pursued.

Question: Dr. Cox, are we doing any harm by using a low antigen titer Salk vaccine?

Dr. Cox: I have data which I have never published, because at the time I didn't fully understand the significance of it. While working with the USPHS in Montana many years ago on the development of killed vaccines for Rocky Mountain spotted fever and epidemic typhus fever, I observed that vaccinated guinea pigs challenged with Rocky Mountain spotted fever or typhus would sicken and die before the controls. I couldn't find anything about this in the literature, and it bothered me for about a year. I learned that by increasing the antigen five to tenfold into the range of a 100 million to a billion organisms per cc. of vaccine, this adverse effect was corrected and an effective product obtained.

We had the same experience at Lederle with Japanese B vaccine. Lots of vaccine which had less than 100 million virus particles invariably would cause the vaccinated mice to die before the controls when challenged. The same thing happened to us when we tried to produce a vaccine against lymphocytic choreomeningitis. During the war the Division of Biological Standards made the same observation with Japanese B encephalitis vaccines.

I mentioned this observation and correlation in a paper in 1954, namely, that with a low antigen killed vaccine you stand the danger of actually doing more harm than good.[47]

The first field evidence we've had that there may be something to this clinically was the Type III polio epidemic in Massachusetts last year, where 47 per cent of the paralytic cases occurred in those who had three or more injections of the Salk vaccine.[48] The lower incidence of paralytic polio (37%) in the unvaccinated group raises the question as to whether we have produced a greater sensitivity in the vaccinated individual. If the investigators have correctly estimated the numbers of vaccinated individuals, the clinical finding confirms what we've seen in the laboratory. It is hard to be sure that this is the case. But we have supporting laboratory experience that susceptibility is increased by sensitization with low antigen vaccines. This is an immunologic fact supported by USPHS findings. I advised against the manufacture of the Salk vaccine because I knew from experience that one to four thousand formalin would not kill the poliovirus and that high concentrates of antigen are necessary for an effective killed vaccine. With low concentrates of antigen you may do more harm than good.

Live poliovirus vaccine

Dr. Cox: When measured against its killed counterpart, a live virus vaccine is always a superior vaccine. It invariably costs about half of that of a killed vaccine. The only reason for not making a live typhus vaccine, for instance, is that technical problems of sterility would be difficult to overcome on a production basis.

We chose the oral route for live poliovirus vaccine because polio infects through the oral route. We also knew from our work with other viruses that the best way to immunize is to follow nature where possible. Since nature was immunizing 999 persons out of a 1,000 against polio without any trouble, the idea was to follow nature's example but to cut the risk down as much as possible.

The work we did on Newcastle disease in chickens was a perfect model in every respect for polio. Although the Department of Agriculture had previously stated that they would not license a single live virus product, today it is hard to find a killed virus product in veterinary medicine. They too found out that living virus vaccines are superior. They give a higher degree of longer-lasting immunity. They cost less to make and administer.

Polio is unique because many more people get the infection than the disease. When you think about it, theoretically it should be the easiest of all viruses to modify. Rabies, by comparison, is 100 per cent fatal when introduced into the brain tissue of any warm blooded animal. Yet, we are able to modify the rabies virus so that we can inoculate it directly into the

brain of warm blooded animals with no sign of the disease. When challenged with virulent strains of rabies, these animals will withstand 100,000 lethal doses inoculated directly into the brain. If we can do this with rabies, we certainly should be able to modify polio, which produces clinical signs of the disease in so few people.

A complicating factor in polio was that we were dealing with three different types, each of which had to be modified. Furthermore, we felt that we had to modify these viruses by adaptation to a foreign host. In making yellow fever vaccines, we learned that when you take a virus and adapt it to an unnatural host, it loses its virulence for the original host. This central basic principle was observed by Jenner also, when he found that cowpox had the ability to immunize against smallpox. In yellow fever, therefore, scientists purposely adapted these strains to new hosts, first, by adaptation to the brain tissues of suckling mice, then to mixed tissues of suckling mice in tissue culture, then to chick embryo tissue cultures, and finally to the chick embryo in the egg itself. Even though it has been claimed that you cannot grow polio in chick embryo, we succeeded in growing all three strains in chick embryos. The reason we desired this was that experience has shown the absence in chick embryo of extrancous virus contaminants which cause illness. Chick embryo for all practical purposes is a pretty sterile package.

The only thing that balked us after we got the polio strains in chick embryo was their poor antigenicity. Type I was completely nonantigenic; Type III was so poor that its cost would have been prohibitive; the only one that was half-way antigentic was Type II. In other words, we learned that it is unwise to continue passage in nonmammalian tissue for long periods of time. The big danger in modifying live virus is not stopping at the right point. If you carry it too far, you overmodify and lose what you're after. It's safe but it won't immunize.

We have developed our strains of virus so that they are nonvirulent to monkeys in the range of 100,000 to a millionfold. We know that in some instances as little as two tissue culture particles of some wild strains of polio when placed in the brain, or as little as five tissue particles inoculated intramuscularly, will paralyze monkeys. It's most unusual, however, for our modified strains in undiluted form with a concentration range from 30 to 40 million virus particles per cc. to paralyze monkeys by direct intracerebral inoculation.

Since the chance of getting paralytic polio from a natural infection of wild virulent viruses is only one in a thousand, modified poliovirus adds an additional safety factor of at least 100,000, reducing the risk to about one in 100 million or ten in a billion. Furthermore, we don't need 30 million virus particles for an infecting dose. We need only somewhere in the range of a 1.5 million to 3 million virus particles. We do not have to concentrate anywhere from five to tenfold, as in the killed vaccine; instead we dilute.

A live poliovirus vaccine needs many more virus particles to establish an immunizing infection than any other live virus vaccine I know. This may be due in part to the destruction of virus by gastric juices. It could be because our strains may be modified more than they need to be. At any rate, all of these factors must be worked out quantitatively, for we have to know just how many virus particles we're feeding if we are to come out with a better product.

The Type I and III components of our vaccine are now standardized to contain at least 1,200,000 to 1,500,000 live virus particles. In our Type II, which has been overmodified, we need 3 million virus particles for a 90 per cent immunizing dose. Now we are in the process of increasing Type II's power to infect. We do this by feeding the virus to man, having him shed the virus as long as possible, recovering the virus in the stool, and obtaining pure strains through tissue culture. Then we test the recovered viruses in monkeys and isolate those with minimal virulence. Such strains then have the ability to infect human cells, which is what is needed, because you cannot immunize unless you can infect.

It must be remembered that you cannot immunize the gastrointestinal tract with killed vaccine, even in large amounts.[49] Although the killed vaccine does induce antibodies in the blood, this does not prevent the person from becoming a carrier and shedding poliovirus.[50] One can recover wild poliovirus strains as well as modified virus strains in Salk-vaccinated persons.

The principle of the live virus vaccine in polio is analagous to protecting your house against the

weather. You don't fill the rooms with concrete. All you do is paint the outside walls because they are the site of exposure. In the case of a natural polio infection, if you are one of the 999 lucky ones out of a thousand who does not get the disease, the virus grows in the cells of the gut, and viruses are shed anywhere from ten days to as long as six months without symptoms. During this process antibodies appear in the blood. As a result of this infection the cells of the gut become resistant for varying periods of time, depending on the number of cells infected. I have an example of this in my three grandsons. The older ones, who had been vaccinated more than once, did not shed Type II on refeeding. The youngest one, however, who was immunized only once, a year earlier, shed virus for several consecutive days and then stopped.

If you proceed gradually, and quantitatively, and imitate the norms of nature as a model for improvement, you are on solid ground. In this connection we have benefited from experience with 10 or 12 live virus vaccines used routinely in the United States in veterinary medicine.

Using live virus vaccine is the only possible way to eliminate wild virulent strains in nature. The gastrointestinal tract must be made so resistant that wild strains cannot get a foothold. This cannot be done with a killed vaccine. We know this from hog cholera. In the 35 states that have prohibited the use of anything but live virus vaccine, the wild strains of hog cholera have disappeared because the swine have become resistant to infection.

In the beginning we moved slowly and cautiously. We started with my immediate family—my daughter was the first pregnant woman ever immunized. Then we included neighbors, then employees at our Pearl River plant and their families. At present we have immunized over 900,000 people in something like 20 different countries on four continents with monovalent feedings and over 1.5 million people with trivalent vaccine. The vaccine now has over a 90 per cent take, and over 90 per cent of those missed, whether it be Type I, II, or III, can be immunized by a second feeding.

We do not claim that this product will result in life-long immunity. One does not even get life-long immunity on a mild exposure to a natural poliovirus infection. This is something we have to continue to study. In this country it is unusual to find antibody titers as high as one to two thousand; but in South America it is not unusual to find pregnant women with titers in excess of 8 to 10 thousand, because they are constantly being battered by reinfecting doses.

Live polio vaccine will be cheap enough so that you can afford it once a year, however, if it turns out that it's needed that often. This is important because the United States is not the only country in the world that needs polio vaccine, and in other countries low cost is more important. Polio vaccine is needed particularly in the tropics where there is plenty of polio even though it has been said for years that the tropics are not affected by this disease. One of the most severe epidemics of Type I polio in medical history occurred in Costa Rica in 1954.[51] They had over 1,000 cases in a total population of approximately one million.

We began our basic clinical investigations in Minnesota particularly because University of Minnesota and state health department physicians felt as we did that killed vaccine was not the answer. We began in 1957 and are now in our fourth year. We gave them all of the facts of our product. We held back nothing. We let them know the unanswered questions.

We learned from our initial studies[52] on 25 babies that babies shed virus in quantities as high as a million virus particles per gram of stool. Some of these babies shed virus as long as three months. Practically every member of the family picks up this polio infection whether they've been Salk-vaccinated or not. The important thing is that there were no signs of illness, neither in the babies fed, in the family contacts, nor in the community.

In 1958 we did a larger scale double-blind study[53] in the university community of Como Village in Minneapolis with coded vaccine. Only the state statistician knew the code. Neither the doctor, nor the patient, nor those at the State Laboratories who ran the bloods and stools of these 550 people knew who had received the vaccine and who the placebo. When the code was broken, we found that we had about a 90 per cent antibody response in vaccinated individuals and about a 14 per cent increase in antibodies in the placebo group. We discovered that the infection caused by modified viruses is essentially a household disease just as polio is normally.

We went into two epidemics, a Type I in Colombia[54] in 1958, and the tail end of Type II (surprisingly enough it was Type II) in Managua,[55] the capital of Nicaragua, in 1958. The Type I epidemic was caused by an exceptionally virulent strain—two virus particles paralyzed monkeys. Fifteen verified cases had already been reported. We vaccinated over 7,000 children with monovalent Type I followed by Types II and III. Within eight days no more cases were reported, and not a single case has been reported since then. But we cannot make the claim that we broke the epidemic because we have no way of knowing what the future of that outbreak would have been.

In Nicaragua in a highly virulent Type II epidemic 254 paralytic cases had been reported. Of the 251 cases in children under age 10, 217 were under age 2. We went into Managua and vaccinated over 42,000 children under age 10 during a 12 day period with Type II, and then later fed Type I and III. Even though polio had been reported in Managua every month since 1949, with the exception of three months following the 1953 Type I epidemic, they had a 10½ month period without a single case reported. Polio has come back to Nicaragua this year in the outlying districts, but it has spared Managua. This year we moved into the outlying districts and fed 35,000 doses of trivalent vaccine. Within six days there wasn't a single case of polio reported.

Here again we may have been hitting the tail end of an epidemic, but it seemed to break right in the middle. We can't conclusively say one way or the other that we did or did not stop the epidemic, but we do know that a person who is fed this vaccine will begin to show the presence of virus in the stools on the third or fourth day after feeding indicating that the cells in the gut are infected. Type II sheds for a maximum period of two weeks; Type I for about a month; and Type III stays within the norm of six weeks. We find circulating antibodies in the blood on about the ninth or tenth day, and they reach a maximum peak in about 30 days. By the end of one year they start to decline gradually.

We have fed this vaccine under all kinds of conditions. We fed it in Finland, and in West Germany where presently we are immunizing West Berlin. We started the latter on May 12. I checked this morning and they have already fed 271,000 children and estimate that by the middle of June they will have fed about 450,000 under 11 years of age. We've worked in France, Spain, Italy, Israel, slightly in Argentina, on a rather good scale in Montevideo, in Peru, Colombia, Nicaragua, Costa Rica, Haiti, heavily in Cuba, in California, Minnesota, New York, New Jersey, and Florida, and in Canada, Japan, and Taiwan.

In Latin America we have worked with the approval of the local health officer and the Pan-American Sanitary Bureau. This year the entire country of Costa Rica has been singled out to be vaccinated because of the severe epidemic they experienced in 1954. About three weeks ago I heard from the Costa Rican minister of health that they have succeeded in feeding trivalent vaccine to 281,000 children of an estimated 460,000 under the age of 11. There's no point in going above that age, because by the time Costa Rican children are 10 or 11 years old, they have all had experience with the three types of polio. He reports a conversion rate of about 93 per cent to Types I and III, which independently confirms our conversion figures.

Other findings are of interest. In Cuba we carried out a study[56] with Dr. Juan Embil, Jr., who fed trivalent live poliovirus vaccine to children with acute infectious diseases such as, measles, mumps, influenza, and even typhoid fever to determine contraindications to the use of the vaccine. We found none.

Out of 360 pairs of blood (pre- and post-vaccination) that we tested from Cuban children of school age, we found 76 children who lacked antibodies to one type or another. Actually they had 91 antibody gaps in their Type I, II, and III antibody structures. A single feeding of trivalent vaccine filled in 80 of the 91 gaps for a conversion rate of 88 per cent, and converted 65 of the 76 children to a triple positive status for a conversion rate of 86 per cent.

In western Massachusetts where we tested 123 paired bloods,[57] 67 individuals started out with 115 antibody gaps. A single feeding of trivalent vaccine filled in 104 of the 115 gaps for a conversion rate of 90.4 per cent, and 56 out of the 67 persons were converted to a triple positive stage for a conversion rate of 84 per cent.

As you may know, in February this year Dade County including Miami began a county-wide

mass vaccination program with our trivalent vaccine. The data from there are actually the best we've seen.[58] That's partly because we corrected the Type II component, which has been giving us comparatively poorer results, by doubling the quantity of Type II virus in the vaccine. To give us an idea of the results, they sent us 300 coded pairs of blood. We received them in lots of 20, and all we knew was that each lot included 10 matching pairs.

After the code was broken, we found they were all from young adults at the University of Miami. Of these 300 students, 161 were not triple positives and 25 (8%) were actually triple negatives — they had no antibodies at all. This was a surprising fact because in Florida's subtropical climate they should have had plenty of experience with natural polio infections, as well, perhaps, as exposure to Salk vaccine.

In the polio virgins we filled in 25 of the 25 gaps for Type I, the type responsible for 85 per cent of paralytic polio cases. We filled in 19 of the 25 gaps for Type II, which accounts for 3 per cent of paralytic polio, for a conversion rate of 76 per cent. And we filled in 23 of the 25 gaps for Type III, which accounts for about 12 per cent of paralytic polio, for a conversion rate of 92 per cent. These gaps in the antibody structure of 25 triple negative, polio virgins were filled in by a single feeding of trivalent vaccine.

In the group of 161 students not triple positives, the conversion rates were as follows: In Type I 97 of 99 gaps filled, 98 per cent; in Type II 70 of 79 gaps filled, 89 per cent; and in Type III 80 of 85 gaps, 94 per cent. We filled in a total of 247 out of 263 antibody gaps for an over-all conversion rate of 94 per cent on a single 2 cc. oral dose of trivalent modified live poliovirus vaccine.

I've talked long enough. The only other thing I can say is that the live poliovirus vaccine is coming. It takes time. The one thing I am sure of in this life is that the truth always wins out.

Dr. Ratner: Dr. Cox's vaccination figures deserve comparison with the 1954 field trials of the Salk vaccine. The Cox live poliovirus vaccine has now been used by many investigators in over 2.5 million people with millions more in the process of being vaccinated. The other two live virus vaccines under study have been used in additional millions. The question of safety has been paramount in the minds of these investigators. On the other hand, the Salk vaccine was used in only 400,000 persons in a single field trial in a study[59] which assumed safety and was primarily designed to determine effectiveness. These figures reinforce Dr. Greenberg's thesis that the USPHS was premature in licensing the Salk vaccine and is now excessively overcautious in licensing the live virus vaccine.

Dr. Kleinman, will you bring this discussion to a close? Dr. Kleinman has recently spent several months in Latin America studying firsthand the results of field trials there.

Dr. Kleinman: I want to make a few points by taking you out of the laboratory and away from the statistician's computer without raking up the ghosts of long dead monkeys and waving their shrouds in your faces. In the final analysis the important issue is What does this vaccine do to people and among people? Our Minnesota studies demonstrate a number of things. I would like to bring these to your attention because I feel work such as this must go on on the American scene within groups of people who have the same way of life to which you and I are accustomed.

First of all, the Minnesota studies are American in the sense that we're using the vaccine in people who are living in a way we are accustomed to describe and to understand. Secondly, the Minnesota studies were the first to put these modified poliovirus strains into a community whose nature approximated our normal way of living. Prior to this, these strains were used in isolated individuals and in institutional environments. Thirdly, the Minnesota studies prove what has previously been denied: that it is possible to do a controlled study with the oral live poliovirus vaccine. Finally, the Minnesota studies demonstrate that it is possible to secure definitive results in a population which has had considerable experience with the Salk vaccine.

The importance of the Minnesota studies does not lie in their number, but rather in their design. I want to emphasize the word study. Even though we have involved 100,000 people in 1960, we still firmly believe we are *studying* the oral polio vaccine strains. Although the numbers are large, we are not carrying out a mass immunization program.

Important characteristics of our design are (1) Our studies are placebo controlled. This includes the 100,000 people we are studying in 1960. (2) Our subjects receive complete public health nursing and medical surveillance. We do not feed and forget. We feed and follow through. (3) Our studies are double-blind. Only one person, the statistician, knows who is getting the vaccine and who is getting the placebo. On the basis of our experience[60] I can assure you that in your own community you can make a scientific and controlled study.

Now, briefly, what have we found in Minnesota?

We have found that these strains are good antigens. They will produce a conversion from titers of less than four to an appreciably higher titer in 90 per cent of cases. Type II is the poorest. Type I and III are both excellent.

We have found, within the limits of our numbers, that these vaccines are perfectly safe to use. Because our studies have been controlled, we can unequivocally state that there have been no reactions. Before I left Minnesota for Russia, more than 50,000 persons had been fed the vaccine in Minneapolis and St. Paul, and we had checked out all reports of illnesses that occurred shortly after feeding. I did this personally. In Minneapolis, where more than 30,000 were fed, I had to make only 15 housecalls. What I saw was run of the mill. There was no central nervous system disease, just prodromes of measles, follicular tonsillitis, atopic dermatitis, and other conditions you normally find in a community.

We have found there is no great community spread of these viruses. Concern for spread has been a bugbear to many individuals. While these viruses will spread fairly rapidly and thoroughly within any one family, they will spread from household to household within the neighborhood only to the extent of 5 to 14 per cent, depending upon the type. So you don't have to worry about creating an epidemic secondarily through the spread of viruses you originally fed.

We have found, by taking time out to study their natural behavior, that these modified viruses do everything that wild viruses do except produce the disease. In a certain percentage of vaccinees the virus can be recovered from the stool, of course. The fed strains can also be recovered from the pharynx, even though the person has circulating polio antibodies in the blood to begin with. And the virus can be recovered in the blood, which indicates a viremia following the feeding of these vaccines. Those persons with virus in the pharynx and in the blood have no subjective symptoms, however, and the examiner can see nothing objectively.

How long does the immunity last? We don't know. In those that we have studied we know that after a year, even though there is a general drop in titer from the originally induced titer, the antibodies persisted in 50 to 80 per cent of the adults, and in 63 to 75 per cent of the children tested.[61] This is in individuals in whom we are certain that it was we who produced the original antibody change. We are not including those who started with either natural antibodies or Salk-produced antibodies. Other data show that the presence of the latter have no additional effect.[62]

My experience in Latin America is this: Nobody can say that an epidemic was stopped. There were no controlled studies there. But over a million people have been completely vaccinated without any incident at all and, in the countries of Latin America where temperaments are mercurial, emotions excitable, and health departments political, I'm sure that if an incident had occurred it would have come to our notice and to everybody else's notice. The conversion rates in Colombia and other places are remarkably close to the conversion rates we achieved in Minnesota. I've gone over the Costa Rica data carefully. I am satisfied that they have done a good job of surveillance, because the central nervous system disease that they have categorized at the end of a year's observation is remarkably the same in content to what we have found in Minnesota.

There are a lot of important things we don't know about this vaccine. Although we know that it's a good antibody producer, we can't actually say it will protect against polio until we can measure it against a direct challenge by the disease. This has not yet been done. Reasoning by analogy, however, we can assume, because of the antibody responses, that it should protect against the direct challenge by polio itself.

I am not sure that we yet know the optimum dosage schedule. It may be that one feeding is not sufficient, just as one wild polio infection may not completely immunize a child. I don't

think we are quite sure how long the immunity is going to last. As Dr. Cox stated, it is not going to be life-long, but what it's going to be in terms of years I don't think anybody can tell. These are things for the future to disclose.

In the meantime, let me assure you from my direct experience in Minnesota and from my vicarious but close contact in Dade County, Fla., and from my experience in South and Central America, that these strains are safe. From the laboratory standpoint they are potent antigens. The Cox live poliovirus vaccine is worthy of the consideration of people who are working in preventive medicine and public health. I do hope that more people will pay more and more attention to their use in this country, because it is the data gathered in this country that will ultimately count in granting the license and in gaining universal use of this particular preparation.

Dr. Ratner: We have attempted in this panel discussion to present you with a sober, candid exposition of the facts as we know them and as they relate to current questions surrounding decisions to be made in the use of Salk, and oral live virus vaccines. I hope you recognize that the panelists have shown unusual freedom from extra-scientific considerations and pressures.

During the 1960 polio season, epidemics may occur. To dramatize the urgency of the decision involved, remember the futility of using the Salk vaccine to combat epidemics despite its proven ineffectiveness[63] in epidemics simply because it is the only vaccine available to us. An objective and fearless evaluation of the Salk vaccine is needed, for this is the necessary ingredient of an intelligent decision as to when the live virus vaccine should be licensed. Obviously, if the Salk vaccine is simultaneously safe and highly effective,[64] the USPHS can take its time about licensing the live virus vaccine. If, on the other hand, polio and polio epidemics remain with us, and children become paralyzed despite three, four, five, and six inoculations of Salk vaccine, and vaccinees die, we cannot take our time.

REFERENCES

A bibliography is available on request to the Journal.

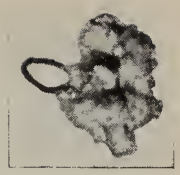
Community hospitals and medical education

Except for this possibility of house staff shortage, the educational picture is bright. Throughout the country programs are being developed that are really valuable, and in many hospitals the enthusiasm for this work is very encouraging. The American Association of Directors of Medical Education, an organization of rapid growth and great vitality, is doing its part. In New England, for example, more than half of the 62 community hospitals which support interns and/or residencies have appointed either full- or part-time directors of medical education, and sound programs of training are being carried out in almost all of them. *Editorial. Alex. M. Burgess, Sr., M.D. Medical Education in Community Hospitals. Ann. Int. Med. June 1960.*

Therapy for Raynaud's disease

Vasospastic conditions of the upper extremity generally termed Raynaud's Disease present a challenge to the medical profession. This disease involves the digital arteries and arterioles. These patients have an increased sensitivity to cold as compared to normal persons. The sympatholytic drugs are of value in many of these patients and have a real range of usefulness. If there is failure of response to conservative measures, sympathectomy is indicated, recognizing that even with adequate denervation, the condition may recur. The severity of the disease and the amount of disability should form the basis for the therapeutic range. In the mild and nonprogressive types, sympathectomy is not indicated. *George H. Yeager, M.D. Factors Influencing Therapy in Peripheral Vascular Disease. Virginia M. Month. March 1960.*

Stone with silk suture.



Total Cystectomy

With Uretero-Ileo-Urethral Anastomosis

Gilbert D. Fish, Jr., M.D., and Lawrence F. Rockey, M.D., *Freeport*

In recent years, an increasing number of articles have appeared in the literature regarding the use of various segments of bowel to replace the bladder. Most of these papers have involved methods of diverting the urinary stream to the outside in such a fashion that ascending infection and electrolyte imbalance will be avoided. Relatively few reports have dealt with the re-establishment of normal urinary tract by means of an anastomosis of an artificial bladder to the prostatic capsule or urethra. [1–5] The case reported herein does not pretend to represent a new surgical technique, but rather to present an additional case where a patient has been returned to a state of apparent normalcy by this type of anastomosis.

A Case Report

A 61 year old white male was admitted to the hospital with the complaint of hematuria of approximately one month's duration. He was otherwise asymptomatic, and had no previous urinary difficulties. He had enjoyed excellent health, his only previous illness having been appendicitis many years before.

Physical examination revealed a well developed white male in apparent good health and with no evidence of weight loss. There was a right McBurney abdominal scar with some skin retraction. The genitourinary system was unremarkable, and the prostate showed no enlargement on digital examination.

Cystoscopy was carried out on Dec. 7, 1959, and a polypoid type of bladder tumor was found. The left ureteral orifice extended through the tumor mass, but the right orifice appeared to be uninvolved. The biopsy report was an invasive transitional cell carcinoma of the bladder.

On December 9 the patient was explored through a suprapubic mid-line incision. The tumor was found to be limited to the bladder itself, did not extend entirely through the wall, and did not involve the prostate. It was, however, more extensive than originally thought by cystoscopy, and it was realized that total cystectomy would be necessary for cure by surgical means. A second biopsy was taken and the wound closed.

The possibility of a total cystectomy with the formation of an ileal bladder was explained to the patient, and he accepted this procedure. Several days were required for suitable preparation of the bowel, and surgery was done December 14.

The original incision was re-opened and extended above the umbilicus. The entire bladder was removed including the anterior peritoneum and transversalis fascia. The ureters were transected about two centimeters from their entrance into the bladder. A small amount of prostatic capsule was included with the bladder, leaving a full two-thirds of the prostatic capsule for subsequent anastomosis.

Multiple adhesions at the site of the previous appendectomy required lysis. Then a suitable segment of ileum approximately 20 cm. in length and about two feet proximal to the ileocecal valve was selected for a new bladder. This segment contained a good blood supply and was quite mobile. The proximal end of this isolated ileum was closed with two rows of inverting sutures, the first of intestinal catgut and the second of fine silk. The distal end was used for anastomosis to the prostatic capsule, in order to

From the Freeport Clinic.

place this segment in isoperistalic position; since they were of comparable diameter, the anastomosis was done with little difficulty. Sutures were continuous 00 chromic atraumatic

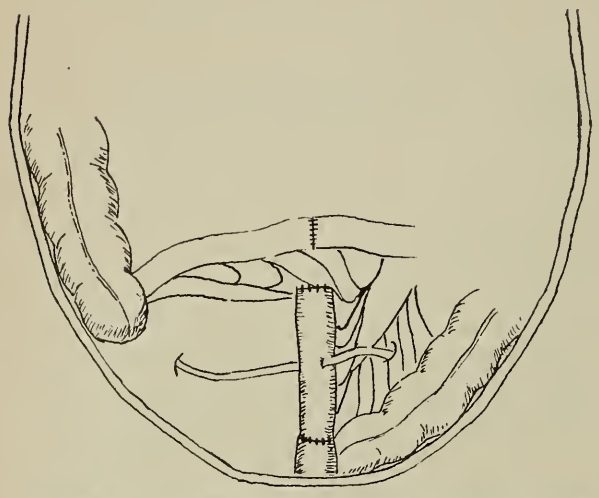


Figure 1. Schematic drawing of artificial bladder obtained from ileum and anastomosed to prostatic capsule.

catgut, followed by interrupted 000 silk. The prostatic capsule took the sutures well, and a secure anastomosis was felt to have been obtained. An end-to-end anastomosis of ileum to ileum was then done to restore the continuity of the fecal stream.

The right ureter was implanted at about the middle of this ileal bladder. The ureter was inserted through a stab wound, the end split and everted, and tacked to the mucosa with fine catgut. Number 0000 silk was used to attach the ureter to the serosa of the ileum peripherally. The left ureter was passed through a tunnel in the mesosigmoid and anastomosed to the ileal bladder in the same manner, in a position about two centimeters more proximally in the bowel.

Ureteral catheters were inserted through a Foley catheter and extended through the ureterointestinal anastomoses well up into the ureters. The Foley balloon was inflated to hold the catheter securely in the ileal bladder.

Because of the absence of considerable peritoneum and some of the fascia, the wound was closed with through-and-through retention sutures of nylon.

The patient had a normal recovery from anesthesia, and the Foley catheter as well as the ureteral catheters drained well. On the second postoperative day, there was some decrease in the rate of flow of urine through the catheters, and it was thought that the Foley catheter might well be occluded with mucus and/or blood clots. The Foley and ureteral catheters were removed, and several hundred cc. of urine with considerable mucus gushed forth through the penis. Another Foley was inserted, and gentle irrigation with normal saline solution was done daily; large quantities of mucus were obtained with each irrigation.

The patient's postoperative course was complicated by a paralytic ileus that eventually responded to conservative measures, including the use of a Miller-Abbott tube for intestinal decompression. His temperature was normal throughout, and his wound healed per primum without any evidence of weakness.

The Foley catheter was removed on the tenth postoperative day, and for the first day the patient was incontinent of urine. Within 24 hours, he began to develop some control of his new bladder, with fewer and fewer episodes of dribbling. Within a few days, he could hold urine for as long as two hours. He was repeatedly



Figure 2. Intravenous pyelogram showing normal upper urinary tract associated with the ileal bladder.

catheterized because of the necessity to irrigate the large amounts of mucus formed by the ileal bladder. He was discharged from the hospital on the eighteenth postoperative day, when he could go as long as two to three hours without voiding and was only occasionally incontinent of small amounts of urine during the night.

During the next four weeks, the patient continued to improve in bladder control, and he developed a forceful stream with no residual. There was considerable amount of mucus in the urine, however. He then noticed the frequent passage of small calculi. (See title picture. Silk suture acted as nidus.) He was therefore readmitted to the hospital for cystoscopy. This revealed several sutures at the site of the ileal-prostatic anastomosis, where stone formation was observed to be taking place. With this exception, there was excellent healing and no evidence of inflammation or granulation tissue. The ileal bladder contained a good concentration of indigocarmine in five minutes, and one orifice was identified at this examination.

Within a short period of time, the passage of stones ceased, and mucus in the urine decreased. An intravenous pyelogram was done ten weeks postoperatively and revealed a normal urinary tract associated with this ileal bladder (fig. 2).

Three months following surgery, the patient was essentially asymptomatic. He noted some frequency during the daytime, but he attributed this to the large amounts of fluids that he was accustomed to drinking. He had no nocturia. Urinalysis showed a rare pus cell and small amounts of mucus. His bladder capacity was about 500 cc. (figs. 3, 4). He has noticed no change in his sexual capability since surgery.

Discussion

In a recent report,[1] the statement is made that the ileum is less suitable than the sigmoid colon for the formation of an artificial bladder with anastomosis to the prostatic capsule or urethra, because the musculature is not capable of sufficient force to empty this newly formed bladder. The case reported here attests to the fact that it is indeed capable of forceful evacuation of urine, and that this is complete to the extent that no residual has been noted on the several occasions when this has been checked.

Our limited experience does not entitle us to comment on the relative merits of ileum versus

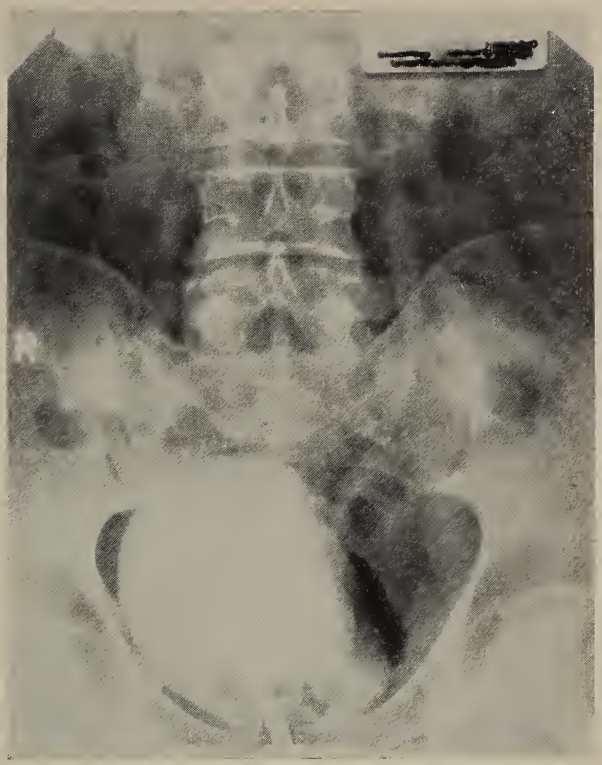


Figure 3. Cystogram six months postoperatively shows good bladder capacity. Note the hydroureter after distention of the bladder with 450 cc. of fluid.



Figure 4. Cystogram after voiding shows the ureters normal in size. Although dye is still apparent in the bladder, there was no residual on catheterization.

colon for use as an artificial bladder. The relative mobility of the ileal segment enabled us to form a mid-line bladder and to thereby carry out the seveal anastomoses without difficulty. Although paralytic ileus was a temporary postoperative problem, intestinal obstruction did not follow. There have been no electrolyte disturbances; both kidneys and ureters function normally; there is some frequency, but no nocturia, and the patient can notice no difference in his voiding now from that of years before surgery.

Approximately one year before this patient's surgery, another patient was operated on for a comparable lesion. In this instance, a similar segment if ileum was utilized for bladder formation, but the ileum was brought through the abdominal wall, and the urine collected in a Rutzen bag. This patient continues to excrete copious amounts of mucus, not appreciably less than that excreted immediately after surgery. It is interesting to note that in the patient reported in this paper, there has been a continued reduction in the formation of mucus. The patient describes his urine as clear, but small amounts of mucus are apparent on gross examination of a collected specimen. A comparison between two isolated cases can do little more than incite curiosity, but it might lead to the following speculation:

Rattner, Moran, and Murphy[6] have reported on the histologic appearance of small bowel segments at various intervals following their use as urinary conduits. In all instances they found the ileum recognizable as ileum for as long as three years. However, in none of their cases was the ileum used as a bladder to function in a "normal" manner. Perhaps if it were used in a more physiologic fashion, with continuous filling and emptying of urine, a different histologic appearance might eventually result. There is certainly good clinical evidence of relatively little mucus secretion at this time in this particular artificial bladder. However, more time must pass before we biopsy this ileal bladder for histologic examination.

Summary

A case is reported in which uretero-ileo-urethral anastomosis following total cystectomy resulted in an apparently normally functioning urinary tract. Forceful and complete emptying of the artificial bladder has been attained by this procedure.

A comparison is drawn between the virtual absence of mucus noted in the urine of this patient and that noted when the ileum is brought through the abdominal wall as a permanent fistula.

REFERENCES

1. Gil Vernet, J. M.: Technique for Construction of Functioning Artificial Bladder, J. Urol. 83:39 (Jan.) 1960.
2. Mellinger, G. T., and Klatte, P. B.: Uretero-ileo-urethral Anastomosis, J. Urol. 82:459 (Oct.) 1959.
3. Mellinger, G. T., and Suder, G. L.: Ileal Reservoir (Ureteroileo-urethral Anastomosis), J.A.M.A. 167:2183 (Aug.) 1958.
4. Pyrah, L. N.: Some Uses of the Ileum in Urology, Brit. M. J. 1:135 (Jan.) 1956.
5. Shoemaker, W. C.; Bower, R., Long, D. M., Jr.: A New Technique for Bladder Reconstruction, Surg. Gynec. & Obst. 105:645 (Nov.) 1957.
6. Rattner. W. H.; Moran, J. J., and Murphy, J. J.: The Histologic Appearance of Small Bowel Segments Used as Urinary Conduits, J. Urol. 82:236 (Aug.) 1959.

Cystocele and incontinence

Despite statements regarding the relationship of cystocele to stress incontinence, there is no valid evidence that cystocele *per se* is either causative or necessarily associated with incontinence. Many experienced surgeons and gynecologists have tacitly, if not publicly, come to this conclusion. This is based on the failure of anterior repair procedures to eliminate incontinence. This would obviously imply that urethro-vesical support is not the answer, and this has been proven experimentally and clinically. If the urethro-vesical neck musculature cannot remain firmly in apposition over the normal critical length of outlet, then varying degrees of incontinence will occur. Indeed any therapeutic procedure which is not founded on the restitution of such muscular coaptation is irrational and doomed to failure. *Ian M. Thompson, M.D. Management of Urinary Stress Incontinence. Missouri Med. April 1960.*

Rheumatoid Arthritis in Childhood

Priscila Reyes, M.D., and Ira M. Rosenthal, M.D., *Chicago*

WHILE the clinical features of rheumatoid arthritis in adults are well known, there is less familiarity with the disease as it occurs in children.[1–4] Interest in the present status of rheumatoid arthritis in children in Illinois prompted a retrospective analysis of cases seen on the pediatric service at the University of Illinois Research and Educational Hospitals during the past five years. While retrospective studies have serious deficiencies, they are useful in determining the general incidence of a disease at a particular medical center, the course of patients who have been treated, and the therapeutic measures employed. They often are instrumental in modifying the diagnostic criteria for a disease, altering its treatment, and prompting further studies of various facets of the condition. Almost all cases in the present study have been seen one or more times by the authors.

Diagnostic criteria

Rheumatoid arthritis is difficult to define and delineate. In atypical cases, diagnosis is especially difficult because of the marked variation in manifestations, particularly in children. Criteria for diagnosis, therefore, must be defined carefully. The criteria of the American Rheumatism Association are of great value if minor modifications necessitated by the difference in age group are made.[5]

The most important positive diagnostic findings are morning stiffness, tenderness, pain on motion, and swelling of joints. Subcutaneous nodules, typical roentgenographic changes, and positive sheep cell agglutination tests are valuable confirmatory findings. Biopsy of synovial membranes is not feasible in pediatric practice and was not employed in this series of cases.

Department of Pediatrics, University of Illinois College of Medicine.

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The American Rheumatism Association has also defined a group of negative criteria, the presence of which tend to rule out rheumatoid arthritis. They include the rash of lupus erythematosis, the findings of dermatomyositis, the clinical picture of rheumatic fever (particularly carditis), infectious arthritis or tuberculosis of the joints, and erythema nodosum.

We feel that five of these positive criteria and none of the negative should be present for the diagnosis of rheumatoid arthritis in childhood. There should be a history of joint symptoms for at least six weeks. For the diagnosis of probable rheumatoid arthritis at least three of the positive criteria and none of the negative should be present. There should be a history of joint symptoms for at least four weeks. For the diagnosis of possible rheumatoid arthritis at least two of the positive criteria should be present, no negative criteria. Duration of joint symptoms should be at least three weeks.

By using these criteria to define rheumatoid arthritis in childhood, it is possible to establish greater uniformity in diagnosis so that the results of different forms of therapy can be evaluated more easily. While it is not difficult to recognize the typical well developed cases of rheumatoid arthritis in childhood, diagnosis is often difficult in the early stages of the disease and in cases that satisfy only two of the positive criteria.[3] The differential diagnosis often includes one or more other diseases, and careful prolonged study may be necessary before diagnosis is securely established. In our cases, the differential diagnosis has included rheumatic fever, septic arthritis, osteomyelitis, disseminated lupus erythematosis, sickle cell disease, lymphoma, and infectious mononucleosis. Each of these conditions can be excluded by appropriate diagnostic tests and by prolonged observation of the course of each patient.

During the past five years, 16 cases of rheumatoid arthritis have been treated on our pedi-

atric service. By the criteria of the American Rheumatism Association, 7 were definite, 7 were probable, and 2 were possible cases. There were 12 girls and 4 boys in the group. In 5 cases, the onset was between the ages of 1 and 3 years, in 3 between the ages of 3 and 5 years, and 8 cases between the ages of 5 and 12 years.

Clinical manifestations

Fever was a presenting symptom in 8 of the children, and in 4 of these, the temperature curve was spiking in character. Initially, 11 of the 16 had definite arthritis; the other 5 had arthralgia without definite arthritis. Joint stiffness was present in 5 cases. Rash was present in 6 in the initial stages of the disease. Subcutaneous nodules were found in only one case. Joint involvement initially was multiarthritic in 13 cases and monoarthritic in 3. The knee was involved in 6 making it the most frequently involved joint. Those of the ankle, wrist, shoulder, elbow, and spine, the temporomandibular joint, and finger joints followed in that order of involvement. Primary involvement of large joints like the knee, rather than small joints such as those of the fingers, is characteristic of the juvenile form of rheumatoid arthritis.

As the disease progressed, more joints became involved. All 16 of the patients had tenderness and swelling in one joint, 14 in more than one joint. Swelling was symmetrical in 11 of the cases. Morning stiffness was present in 5. Characteristic changes shown by roentgenograms, mostly osteoporosis, were present in 6.

Laboratory findings were of limited positive value in diagnosis. Anemia was found in five and five had a leucocyte count of more than 10,000/mm.[3] Particularly confusing was one child who persistently had a markedly elevated leucocyte count with a shift to the left, which on one occasion reached 96,000/mm.[3]

The sedimentation rate, which is not specific for rheumatoid arthritis, was high in 13. The sheep cell test was done in seven and was negative in all. In the 10 cases in which a lupus preparation was done, the test was negative. The antistreptolysin titer was negative in the 10 cases in which it was performed. It is evident that laboratory examinations are entirely subordinate to the clinical findings in the positive diagnosis of juvenile rheumatoid arthritis. They have been of great value, however, in ruling out rheumatoid arthritis in some children by establishing an alternative diagnosis.

Treatment

There was no rigid departmental policy regarding use of adrenocortical steroids in this series, and in general the more severe cases (9) were more likely to receive them; those less severely involved received salicylates. Some patients were given both types of drugs.

The cases in this series have been followed for periods varying from nine months to five years. At present 4 are asymptomatic and are receiving no medication; 2 are asymptomatic but are still receiving maintenance adrenocortical steroids. Six patients have mild residua; 2 of these are not receiving specific medication, and 4 are still on maintenance adrenocortical steroids. One child with severe progressive disease despite treatment with adrenocortical steroids died from acute adrenal insufficiency early in the course of varicella. It was not possible to ascertain the present status of 3 of the cases. Analysis of this small series revealed no significant differences in results between steroid and nonsteroid groups with regard to long term status.

Discussion

It is evident that juvenile rheumatoid arthritis in Illinois is uncommon, but it is not rare. The cases at the Research and Educational Hospitals are not entirely representative of the disease as it occurs in the state since few of the extremely mild cases and few of the chronic severely crippled cases have been seen in our pediatric clinic.

Our experience tends to conform with that of Edstrom, who found in a much larger series that after five years 60 per cent of his cases had recovered with no residua, 20 per cent had residua but no activity, and 20 per cent had progressive severe disease or were dead.[4] Johnson and Dodd have emphasized, however, that recurrence of activity may take place many years after apparent recovery from rheumatoid arthritis.[1]

It is clear that for management of juvenile rheumatoid arthritis in the absence of specific therapy the physician can employ salicylates, adrenocortical steroids, physiotherapy, occupational therapy, orthopedic measures, and psychological support. Because of occasional irregularity in salicylate absorption, it is advisable to check the blood salicylate level in cases that show

poor response to salicylates. The adrenocortical steroids appear to be of considerable value in the acute toxic form of juvenile arthritis.

Progression of the disease, however, may occur despite the use of the adrenocortical steroids. However, their use in the milder forms of the disease does not appear to be indicated since risks involved in using them, including compression fractures of the spine, are taken without any evidence of improvement in long term results. Discontinuation of systemic adrenocortical steroids, once they have been employed, may be difficult for the physician to achieve, because symptoms may recur when the drugs are withdrawn. In occasional cases where large joints like the knee are involved, local injection of hydrocortisone may be of value. Extreme care must be taken, however, to avoid infection.

In childhood excessive bed rest may be detrimental. It is, of course, necessary in acute toxic cases but in cases that are not in the acute severe toxic phase, ordinary activity is to be encouraged. Provisions for continuation of school work must be made according to the capacity of the patient for activity. Further, the indiscriminate use of plaster casts may lead to ankylosis of involved joints.

A causal relationship between beta hemolytic streptococcal infection and rheumatoid arthritis has not been established. For this reason routine prophylactic therapy with penicillin or the sulfonamides, as in rheumatic fever for the prevention of beta hemolytic streptococcal infections, is not warranted.

The sheep cell agglutination test, the latex particle agglutination test, and similar tests need further study in juvenile rheumatoid arthritis. Positive results appear to be less dependable in children than in adults. There is considerable difference in the percentage of positive results, depending upon the nature of the test employed and the particular series of cases reported.[4,6]

Conclusion

While much can be done to aid the child with rheumatoid arthritis, knowledge of the disease can hardly be considered to be in a satisfactory state with the etiology unknown, no definitive laboratory diagnostic test available, and no effective specific therapy known. Further significant advances in the control of rheumatoid arthritis appear to be dependent upon new significant advances in knowledge of its pathogenesis.

REFERENCES

1. Johnson, N. J., and Dodd, K.: Juvenile Rheumatoid Arthritis, M. Clin. North America, 39:459, 1955.
2. Edstrom, G., and Gedda, P. O.: Clinic and Prognosis of Rheumatoid Arthritis in Children, Acta rheumat. scandinav. 3:129, 1957.
3. Gauchat, R. D. and May, C. D.: Early Recognition of Rheumatoid Arthritis with Comments on Treatment, Pediatrics 19:672, 1957.
4. Edstrom, G.: Prognosis in Juvenile Rheumatoid Arthritis, Arthritis and Rheum., 1:497, 1958.
5. Ropes, M. W.; Bennett, G. A.; Cobb, S.; Jocox, R.; and Jessar, R. A.: Proposed Diagnostic Criteria for Rheumatoid Arthritis, Ann. Rheum. Dis. 16:118, 1957.
6. Mikkelsen, W. M.; Duff, I. F.; Goodson, L.; Coulter, W. H.; and Hertz, C.: A Comparative Study of Recent Serologic Tests for Rheumatoid Arthritis. Paper presented at the 40th Annual Session of the American College of Physicians in Chicago, April 21, 1959.

Pseudoangina

Pseudoanginal pain is more often in the left pectoral region, the patient usually describing the location by placing his hand over the nipple area. Occasionally, in women, the pain may be under the left breast. The pain is frequently described as extending into the left axilla and, less often, down the left arm. While the aforementioned are the common areas, any portion of the thorax may be the source of pain ascribed to the heart by anxious patients; even the abdomen may be implicated. Differentiation from true angina may be made on several bases. Vagueness and atypical history are common in psychosomatic disturbances. Freedom from pain when busy and exacerbation when at rest are usual signs. *Eugene Rinkey, M.D. Psychosomatic Aspects of Heart Disease. J. Lancet. April 1960.*

Community-Based Home Care Programs*

Pearl H. Ahrenkiel, R.N., B.S.†

"Home care programs are defined as organized programs having centralized responsibility for the administration and coordination of services to selected patients at home, through a formally structured group and comprising at least a family physician, a public health nurse, and social caseworker assisted by clerical services and by the provision of essential drugs and supplies."[1]

"The essential characteristics of an organized Home Care Program are considered to be (1) centralization of responsibility for administration, (2) coordination of the various services and resources made available to the patient, (3) the development and use of a medical care team or the opportunity for various disciplines to deal jointly with the health needs of the patient and his family and to develop definitive planning for the patient."[2]

Most home care programs serve chiefly patients with long term illnesses. Organized home care makes available various community health and welfare services for the patient at home, in a coordinated, unified way. This prevents the fragmentation and separation of services, or the gaps that more frequently exist when only part of available community resources are made available. The objectives and purposes of the various programs, generally speaking, focus on the concept that home care is the most satisfactory means of meeting the total care needs of certain patients, or of a patient during certain phases of his illness. Any patient requiring long term care can be considered for home care only when his family wants to have him at home and the home service best meets his needs.

Organized home care programs, as the term is now used, originated in the Montefiore Hospital in 1947, following the pilot project at Syracuse University College of Medicine in 1940. Montefiore, a voluntary hospital for chronic disease, established a department of home care and set out to demonstrate the feasibility of caring for indigent and medically indigent patients with long term illness in their own homes through an extension of hospital services.

Development of programs

The primary purpose of this early program was to alleviate overcrowding in the hospital. The observation, evaluation, and increased understanding of social, emotional, and environmental factors in illness were identified as further purposes; a saving in the cost of hospital care and, by relieving overcrowding in the hospital, a reduction of need for added hospital construction was expected.[3] This early program provided the full range of hospital services to the patient at home: medical, nursing, social service, physical and occupational therapies, housekeeping, laboratory and other diagnostic tests, x-ray, sick-room equipment, medication and medical supplies, transportation, and most important, hospitalization when needed.

Since these beginnings in 1947, 53 home care programs have been developed throughout the country. The concept of coordination of services and centralized responsibility has remained the primary purpose, but with increases in the number of home care plans, greater diversification in administration and variety of services has developed. Some plans provide chiefly social and nonmedical services to home-bound patients: others provide medical services with little or no nursing and social services. Some are operated by or in close liaison with general hospitals; others are operated by visiting nurse associations, health departments, and welfare departments.[4] With these developments, utilization of the program for strengthening medical, nursing, and social casework education has been recognized and in some instances is an additional or purpose for organizing home care programs.

Hospital-based and community-based patterns of home care have one similarity and many dif-

*This is the fifth in a series of articles sponsored by the Committee on Aging.

†Chief, Bureau Public Health Nursing, Illinois Department of Public Health.

ferences in operation. The similarity is that both aim at coordinating services to the patient through centralized responsibility.

The hospital-based programs are serving primarily the indigent patient. It is the opinion of some persons that, when the program is hospital-based, it is easier to retain total responsibility for administration, coordination, and supervision of physician services provided and financed by the hospital, and that the quality of the service is better controlled. Use of in-patient or out-patient facilities may be utilized more freely, and home care programs may work more readily through group conferences of those concerned with individual patients.

By contrast, the community-based program is available to all patients regardless of hospital connection or economic status. The patient pays for services to the extent of his ability, and any remaining cost is borne by welfare agencies or by the home care program itself. It is thought that the relationship between the family physician, the patient, and the family is strengthened in this type of organization. The responsibility for supervision of each profession represented in community-based home care programs remains with the professional agency or the professional organization; e. g., visiting nurse associations supervise nursing; the social agency supervises the social worker. Experience indicates that community-based home care programs tend to be family-centered, and hospital-based programs, to focus on the patient as an individual.

In these days of too few professional personnel to get necessary work done, the community-centered program appears to have advantages in the fuller utilization of personnel. In a city the development of from 1 to 50 home care programs administered by 1 to 50 different hospitals would pose increasing problems related to personnel and expense as the number of hospital programs increases.

Financing home care programs

The costs of providing home care are paid for through a variety of sources:[2]

1. Allocations from the budget of the administrative agency.
2. Grants directly to the program from voluntary or philanthropic agencies or organizations.
3. Grants earmarked for specific items on the home care budget by the contributing organization—for example, salaries or certain services.
4. Payments to the home care program by welfare departments and other public assistance agencies on behalf of specific patients.
5. Services provided and paid for by other participating community agencies, such as visiting nurse associations.
6. Payments from patients and families for services rendered.
7. Tax monies.

Comprehensive prepaid medical care plans in various parts of the country, such as the Health Insurance Plan of Greater New York, are providing some types of home care to an increasing number of persons.

The impact of home care programs on hospital bed utilization has been studied at length. Dr. Peter Rogotz estimates "that about one-fourth of the total number of patient-days of care rendered by a home care program may represent general hospital in-patient days saved. It must be emphasized, however, that any such ratio will vary according to admission and discharge policies of each particular hospital and home care program, and according to many other specific community factors. It would be unwise to apply uncritically, in any situation, the 25 per cent estimate cited above.[4] Indeed, a recent paper by Littauer and Flance offers an estimate of about 75 per cent."[5]

Services provided

Minimal essential services of the patient at home have been defined as medical supervision, public health nursing, and social casework. Review of reports from a number of home care plans show a great variety in methods of providing these services.

Medical services. These have been provided by the patient's private physician, by residents in hospital-centered programs, or by physicians employed on a full-time or part-time basis.

Public health nursing. Home care programs usually contract with existing nursing agencies to provide home nursing care, rather than employ nurses. Visiting nurse services, nursing divisions of local health departments, and other types of existing nursing services have had experience in providing home nursing.

Medical-social casework services. Casework services through a community social agency appear most frequently in the community-based programs. In hospital-based programs, the medical-social caseworker is usually a member of the staff. When a community social agency provides casework services, a mutual understanding should be developed among the various personnel involved in the home care plan, since the members usually have not worked together previously toward a common, specific objective.

Related services as needed. It is desirable to have available for consultation physiotherapists, occupational therapists, dentists, nutritionists, and dietitians. Many programs consider homemaking services, equipment, and supplies as essential. Some suggest providing a plan to permit the family some relief, especially for the person most involved in caring for the patient.

As stated earlier, most patients receiving or in need of home care are chronically ill. Present home care programs handle only a fraction of them. Surveys indicate that 70-75 per cent are cared for at home, many times under quite inadequate conditions. In general, the home care program appears to fit the needs of

1. Patients convalescing from acute illness or acute exacerbation of chronic illness;
2. Patients too sick or disabled to come to an out-patient clinic but not sufficiently sick or disabled to be in a hospital;
3. Patients chronically ill and/or indigent who do not require hospital care;
4. Patients occupying hospital beds solely because a more suitable place for care was lacking;
5. Patients whose psychological and emotional needs would be more readily met, with recovery more rapid, if their family environment could be maintained.[2]

In summary, home care programs have a major role to play in providing qualitative services to the chronically ill patient at home. This kind of service is valued by the family and the patient. Futher values accrue from utilizing programs to increase the understanding of students in medicine, nursing, and social casework, regarding long term illness and its impact on the family, the socioeconomic problems of long term illness, and to give some experience in providing professional services in the home. Home care programs usually require some outside financing. There is a saving in the use made of hospitals, and in many instances there are economies in caring for patients at home. It is important that the over-all criterion for accepting a patient in the home care program be that this type of service can best meet the patient's needs.

REFERENCES

1. A Study of Selected Home Care Programs, U. S. Department of Health, Education and Welfare. Public Health Monograph No. 35, Washington, D.C., Superintendent of Documents, 1955.
2. Organized Home Care Programs in the United States, A Report by the Committee on Indigent Care, J.A.M.A., 164: 298-304, 1957.
3. Jensen, F.; Weiskotten, H. G., and Thomas, M. A.: Medical Care of the Discharged Hospital Patient, New York, Commonwealth Fund, 1944.
4. Rogotz, P. and Crocetti, G. M.: Home Care Programs — Their Impact on the Hospital's Role in Medical Care, Am. J. Public Health, 50: 1125-1133, 1958.
5. Littauer, D., and Flance, I. J.: Home Care Has Made a Place for Itself, Mod. Hospital, 89:77-86 1957.

The Peoria Home Care Plan*

Dorothy L. Campbell, R.N., *Coordinator, Peoria*

The Peoria Home Care Plan is a community-centered program administered by the Visiting Nurse Association of Peoria. The over-all planning rests with the Steering Committee, on which the Peoria Medical Society has representation. All policies of the plan are cleared and approved by the Medical Advisory Committee of the medical society.

The chairman of the Steering Committee is a private physician who also serves as a member of the Medical Advisory Committee. Other members are the president of the medical society and the presidents of the medical staffs of the three hospitals. This committee, of course, changes each year.

The program is coordinated by the medical representatives of the Steering Committee and a public health nurse coordinator. By using the

*This is the sixth in a series of articles sponsored by the Committee on Aging.

team-cooperation approach, the patient is always under the supervision of his private physician. Nurses, physical and occupational therapists, socialworkers, and homemakers are all a part of the home care team. Other skills and paramedical services are obtained from personnel employed by other agencies and institutions; we are indeed fortunate to have an Institute of Physical Medicine and Rehabilitation in our three hospitals.

The patient's family is an important part of the home care team in that it fills the major needs of the patient.

We are fortunate in having the Forest Park Foundation finance our program with a $10,000 grant-in-aid each year. But there is need for recognition by public and private community agencies and by insurance companies in order to obtain sufficient financial support to assure a continuing method of adequate treatment for the long-term, homebound patient. We believe that public tax-supported agencies should pay in full for the services to their patients and that insurance companies should extend their services to include medical, nursing, and homemaker services in the home.

Care provided

In the three year period 1956 through 1958, of 502 referral patients, 289 requiring two or more services were admitted to the home care program, and 153 patients were assisted in meeting their needs for adequate care at home. Of the 442 patients served, 212 were able to leave the hospital and 230 remained at home. This is not a means of emptying hospital beds but freeing a much needed bed for the patient who is acutely ill.

Age distribution ranged from under 40 years (10%) to 60 and over (71%). It is interesting to note that 63 per cent of our patients were age 65 and over, and 50 per cent of them were age 70 and over.

The number of patients admitted to the home care program rose from 76 during the first year to 149 the third year, or 345 patients in a three year period for a total of 30,941 days.

Primary diseases of 345 patients were:

Cerebral vascular accident	110
Accidents (fractures)	64
Arthritis	40
Heart and circulatory	36
Cancer	26
Diseases of C.N.S. (vascular lesion)	29
Diabetes	8
Spinal cord lesions	7
All other diseases	25

Of 253 patients discharged, 150 recovered or improved, 20 were admitted to a nursing home or readmitted to the hospital, 38 died, 3 moved out of the area, and 12 made other arrangements.

There is need for expanding homemaker services to the chronically ill, homebound patients, since at least 50 to 60 per cent of all referred cases need full-time or part-time homemaker service. Consideration should be given to the use of all available community resources in meeting the needs of chronically ill patients not only for homemaker services but for all paramedical services, including dental care and the services of medical-social caseworkers and nutritionists.

Although much equipment has been added to the Visiting Nurses Association loan bureau, vital equipment is still needed.

We are pleased with the increase in referrals by physicians, hospitals, and health and social agencies, but there is need for still more participation by the hospitals and early planning for patient discharge from the hospitals. Once a year the coordinator meets with the medical staff at each hospital and participates in staff education programs; but it is a continuous process of education throughout our community.

Home care is not a panacea for care of all patients with long term illness, nor is home care always cheaper if a multiplicity of services is required. We must consider the use of convalescent homes, many of which are being upgraded to include rehabilitation of patients.

Many times, convalescent homes serve the purpose of a halfway house up to the time the patient is able to return to his own home or to a boarding home where he can still receive the services offered through the home care plan.

EDITORIALS

Preparing your patient for college

As if the family physician were not already overburdened, he is asked today to play an increasingly important role in the lives of his patients of college age. This is true for two reasons. First, as competition for admission to college intensifies—and the end is not in sight—the health factor takes on greater significance. True, a student's academic ability is usually the determining criterion for admission long before the physician's appraisal is requested. But, as campuses become more crowded and methods of selectivity necessarily become more refined, the student's health picture, as reflected in the records of the family physician, will become more crucial.

Second, members of student health services wisely recognize that theirs is a temporary stewardship. They are guardians of the student's health only because he is away from his own physician. Thus, in the interest of thorough and effective continuity, health services must rely on family physicians both to provide candid appraisals, always held in strict confidence, and to counsel the student before he leaves home.

Family physicians are in the best position to prepare their patients for college in the following ways:

1. Help the boy or girl to choose a university which best fits his needs. Some students thrive on freedom; others require more rigid controls.

2. Warn a student who is sensitive to pressure to avoid too many extracurricular activities, especially the first year.

3. Discuss sex education, problems of pregnancy, and the role of alcohol in causing unpredictable behavior.

4. Give the patient a smallpox vaccination or recommend that it be done on arrival at the university.

5. Refrain from supplying drugs such as antibiotics, tranquilizers, and stimulants which, when dispensed *ad lib* to roommates, may produce havoc.

6. Give the patient a booster to pediatric immunizations. Tetanus and diphtheria toxoid can be started at home and continued on campus.

7. Remind the student that family hospitalization coverage may end at age 19.

The family physician performs inestimable service when he prepares a confidential report as follows:

1. Gives candid appraisal of apathy, depression, and fatigue. Psychiatric care is available in most health services. Thus alerted, a suicide might be prevented. (Suicide is the third cause of death in university students.)

2. Provides information which allows graduated gymnasium activity.

3. Sends directly to the health service parenteral drugs and antigens with precise instructions for administration.

4. Provides information on stressful intrafamily relationships.

5. Gives pertinent data on students who, for vague reasons, have had to drop out of previous university settings.

6. Educates the patient to keep his own health record. With the increasing specificity of medicine, the patient who knows his own record on such matters as childhood diseases, antibiotic therapy, allergies, immunizations, and *x*-rays, helps himself and his physician.

7. Consults with the health service when uncertain about the wisdom of sending a chronically ill patient to school. A university is not a therapeutic spa. On the other hand, many students with physical limitations profit from higher education and contribute much to society. Supportive treatment can be arranged.

It is a chore to complete the many diverse forms for patients. Student health services should adopt uniform records and in turn should provide family physicians with a report on any health problems the student encountered while on campus. As higher education becomes more precious, the greater is the need for better communication between family physician and health services. Health problems should not be permitted to block educational goals.

Leona B. Yeager, M.D.
Director of Student Health
Northwestern University

Adrenal insufficiency in politics

Complications associated with the prolonged use of corticosteroids in the treatment of many inflammatory, allergic, hematologic, and neoplastic diseases are well known both to the medical profession and the lay public. Recent articles in the press mention that the Democratic candidate for President of the United States is said to take cortisone because of Addison's disease (adrenal cortical insufficiency). The formerly grave outlook for patients with adrenal insufficiency together with the known complications associated with chronic corticoid therapy have made many people question the advisability of an individual afflicted with this condition being given the enormous responsibilities of heading our government. Such conditions as emotional instability, decreased resistance to infection, peptic ulcer, osteoporosis, and acute withdrawal adrenal insufficiency are not conditions the public wishes to have afflicting their chief executive.

The dose of cortisone necessary for replacement therapy in Addison's disease should not, however, produce any of these complications. A distinction must, therefore, be made between the effect of pharmacologic and physiologic doses of the drug on the patient.

In patients with adrenal insufficiency the amount of adrenocortical hormone should be that necessary to maintain normal mineral and glucocorticoid effect. On the other hand, in order to produce the anti-inflammatory effect of this drug in rheumatoid arthritis and related diseases, it is necessary to give doses that eventually produce abnormal mineral and glucocorticoid effects with the eventual development of Cushing's disease.

Thanks to the availability of cortisone and hydrocortisone, Addison's disease has become a condition more easily treated than diabetes mellitus. Granted that acute adrenal insufficiency may develop suddenly in a well controlled Addisonian patient if an acute infection or other stress phenomina develop, competent medical management controls these emergencies. A patient with this disease under expert medical supervision, and well educated as to his own problem, should be able to lead a full and useful life. Addison's disease should not under these circumstances have any effect on his survival. It is conceivable, however, that because of the improved feeling of "well being" produced by doses of adrenocortical steroids greater than physologic doses, a patient with Addison's disease may inadvertently be maintained on too high a level of the drug and thereby develop the complications associated with pharmacologic doses of the drug.

Therefore, the decision as to the responsibilities and activities that a patient with Addison's disease can safely assume depends greatly upon the know-how and judgment of both the attending physician and the patient himself.

Samuel G. Taylor III, M.D.

Strange paradox

The National Foundation has been pushing the Salk vaccine since it was introduced several years ago. More recently they sent out a release in which they admit that " . . . there is strong evidence that a live virus (oral) vaccine may turn out to be an even more effective weapon . . ."* This is an innovation, considering their strong stand on the 90 per cent effectiveness of the Salk vaccine.

The Foundation was so sure that polio was licked that Mr. O'Connor announced last year that they were seeking new fields to conquer and had aimed their guns in the direction of rheumatology. This was done despite the fact that polio was on the increase and scattered epidemics were reported from time to time. These were blamed on lack of cooperation in using the vaccine—a doubtful cause provided the vaccine was beyond reproach.

Meanwhile, the proponents of the three oral vaccines had to conduct their field tests in other countries. These vaccines were regarded as too questionable for testing in this country. But the results have received so much publicity that the

Foundation can no longer ignore the competition. The USPHS has entered the picture, and over 40 detailed reports on massive campaigns and field trials have been made.

The Foundation waited until the oral vaccine was given to more than 50 million people before agreeing that it was promising. Remember the glowing reports that the Foundation released to the public several years back when only a few thousand had received the Salk vaccine.

*Rivers, T.M.: Killed-Virus vs. Live-Virus Vaccines against Polio, National Foundation Release May 18, 1960.

Alveolar proteinosis

A new chronic pulmonary disease characterized by nonspecific respiratory symptoms and specific x-ray and pathologic findings was described in 1958 by Rosen, Castleman, and Liebow.[1] Since then additional cases have been reported in American literature, but it is doubtful whether the total number on record exceeds forty.

For reasons unknown, the alveoli are filled with a proteinaceous material that extends occasionally into the smaller bronchioles. The substance consists of granular eosinophilic material that stains positively with periodic acid Schiff stain (PAS positive) indicating the presence of mucopolysaccharides.

These secretions produce a definite alveolar-capillary block leading to cyanosis and pulmonary insufficiency. But unlike other forms of the alveolar-capillary block syndrome, the alveolar walls and the interalveolar interstitum is normal. There is no fibrosis, cellular infiltration, swelling nor inflammatory reaction.

The disease usually develops insideously in young adults. There is a slow progression of dyspnea, weakness, fatigue, increased cough, and weight loss. There is a paucity of physical signs unless complications develop. Cyanosis may be noted, and clubbing of the toes and fingers may develop in advanced cases.

The most typical x-ray findings are those of a fine, soft, diffuse, bilateral, perihilar-radiating, floccular-appearing density. There is no cardiac enlargement or hilar adenopathy. The x-ray is distinctive but not diagnostic. A definite diagnosis is made through lung biopsy.

Pulmonary alveolar proteinosis is characterized by a progressive pulmonary insufficiency hastened by secondary infection with a significant loss of functioning lung volume. The mortality is 30 per cent. Antibiotics and steroids are of little value unless complications develop. Best results are obtained with iodides. The proteolytic enzymes, such as Tryptar® and Varidase®, also help to clear away the material.

Brucellosis

Brucellosis is now mainly an occupational disease in the Middle West. At the Mayo Clinic* more than half the patients with this condition were farmers or were otherwise occupied with animal husbandry.

Diagnosis is made with certainty only by cultivating Brucella organisms from blood, body fluids, excreta, or tissues. The agglutination test also is of value. The Mayo group is dubious of a positive skin test which could be correlated with the disease, but others believe that the test indicates a clinical or subclinical past infection rather than simple exposure to the disease. The interpretation of this test is controversial.

Four types of brucellosis are recognized today. The first is the bacteremic type; the organism is cultured from the blood. Its victims have high and rising agglutination titers. In the serologic type the patient has the systemic manifestations of the disease with a positive agglutination titer but a negative blood culture.

The localized type is diagnosed by obtaining Brucella organisms from specific tissues such as the lung, liver, and spleen. Agglutination titers are low or absent, and the blood culture is negative. The fourth type is a mixed form, usually of bacteremic and localized types.

The Mayo group considers chronic brucellosis a doubtful entity because it is shrouded with emotional factors. A weakly positive skin and/or agglutination test in a patient with psychosomatic complaints is of questionable significance unless symptoms are localized.

Tetracycline, or one of its analogues, along with streptomycin is the treatment of choice. The dosage is 500 to 750 mg. of tetracycline every 6 hours with 1 Gm. of streptomycin intramuscularly twice daily for two weeks. Streptomycin is reduced to 1 Gm. daily when lesions are localized.

*Alexander Schirger et al.: Brucellosis: Experiences with 224 Patients, Ann. Int. Med. 52:827-837 (April) 1960.

AT THE EDITOR'S DESK



Gastric Hypothermia for Hemorrhage

Minnesota Medicine carried an article in May on the use of gastric hypothermia in controlling massive gastrointestinal hemorrhage, written by O. H. Wangensteen, M.D., and his group.

The stomach is cooled to 15°C. by inserting a balloon through which an ice-cold 30 per cent alcohol-water mixture circulates. An alternate method was to insert an open tube and slowly inject a near freezing milk mixture. Gastric secretion is reduced considerably, and the pyloris almost closes.

Excellent results were obtained in massive gastric hemorrhage fom peptic ulcer, esophageal varices, and erosive gastritis. Bleeding from duodenal ulcers was controlled in 13 patients, 8 of whom were in shock. The author recommends this plan of treatment for the more seriously ill patient. He also postulated on what effect the treatment might have in closing the more chronic ulcer crater.

Since this article appeared, the Swenko Manufacturing Company of Minneapolis has placed the new gastric hypothermia machine on the market.

Blue Cross-Blue Shield First Choice

More than 55 per cent of the estimated 1,695,000 Federal workers chose to enroll in Blue Cross-Blue Shield this summer.

Government employees also chose the high level-higher cost benefits program in preference to the low benefit-lower cost option offered by Blue Cross-Blue Shield in a ratio of about four to one.

As noted by Blue Cross-Blue Shield, this is a vote of confidence for the organizations, voluntary hospitals, and physicians who sponsor these programs.

Nests of Bacteria for Boils

Chronic furunculosis often resists treatment. Cleanliness, vaccines, and antibiotics are the usual remedies. The British treat this condition by going to the source of the trouble. They found that in 88 per cent of patients with recurring boils the same strain of staphylococci existed in the nasal secretions as was present in the skin lesions. In a few, the organisms were isolated from low grade infections of the eye, ear, or perineal area. A high percentage of cures were obtained when nests of bacteria in the nose were eliminated with neomycin-bacitracin creams. Neo-Cortef was used in the eyes and ears when necessary. The boil area was swabbed with a 1:3000 solution of mercuric chloride. A daily bath was also recommended.

Pharmaceuticals

Merck's new polio vaccine is getting considerable publicity. It is reported in their releases to be far superior to the Salk vaccine. "After two doses given a month apart, every one of the children showed an immune response to all three strains of the virus used in the vaccine. This 100 per cent immunity rate is in striking contrast to that produced by the Salk vaccine . . . . To put the comparison another way, the new vaccine accomplishes the same or better results in eight weeks as the Salk vaccine does in eight months. This can be an important difference when a polio epidemic threatens."

There is no harm in blowing your own horn, but this new vaccine is a good example of why pharmaceutical executives get gray hair. Should the new oral vaccine prove to be superior to the injected type, Merck stands to lose a tremendous market. The exception may occur during a threatened epidemic, but for the present they had better "strike while the iron is hot."

Bacteriologic studies were done in the families of these patients, and many were found to harbor the same staphylococci.

Some cases of recurrent furunculosis were cured only when the family carriers were discovered and treated.

There is no limit to what aspirin can do. "Small daily doses can lower blood cholesterol, relieve the symptoms of diabetes, and can act like thyroid where there is insufficient metabolic activity." This quote stems from a news release concerning an article by Chauncy D. Leake, Ph.D., appearing the New Physician.

Alvodine is Winthrop's new high potency analgesic. In an extensive test Alvodine produced excellent-to-good pain relief in 247 patients. An additional 88 patients reported fair relief. It proved to be better than three other drugs used for comparison. Morphine continues to be an excellent pain killer, but it is seldom if ever used in a double blind test where the efficiency of several drugs is compared.

Scare Selling

It was bound to happen! Radiation has been a recognized depilatory for many years. A recent news release plugging Dr. Lubowe's new book, *New Hope for Your Hair,* had the following title as an eye catcher: "Rising human baldness linked in new book to world nuclear fallout." But in the release itself, the relationship is toned down considerably: "It can be, and possibly is—" Thereafter radioactive fallout is dropped like a hot atomic potato and the more conservative reasons for baldness are considered. It is unfortunate that loss of hair must be added to the current fear of radioactivity—just to sell a book.

Medical Reading Potential

Broadland and Taine of the National Library of Medicine surveyed all medical serial publications for a three month period in 1957, and counted 487 journals in the United States, or 23 per cent of the world's total of 3,579. A later search by others brings the total to 4,828 medical periodicals. During this same three month period, 53,975 articles were published in U. S. journals, a rate of more than 200,000 per year.

By far the largest producer of medical periodical literature on any basis, Broadland and Taine reported, is the United States, which furnishes nearly one-quarter of all the world's journals and/or articles. Germany, France, and England follow in that order. Russia was in eighth place with 3 per cent of the world's output.

Boxers' Bruises and Varidase Buccal

Lederle should know now whether their Varidase Buccal prevented severe and general bruising among the Olympic boxers. It appeared to hasten absorption and healing in an earlier study by Dr. Joseph L. Blonstein, honorary medical officer of the British Amateur Boxing Association. Almost 500 boxers participated in the study — half received Varidase tablets and the rest were given placebos. Eighteen boxers in the control group received severe bruises, whereas 21 received general bruises and abrasions. There were only 7 and 14 respectively in the treated segment. Can we attribute this to the enzymes or were they more fortunate or better boxers?

At any rate, the bruises, abrasions, and sprains cleared up within four to five days in the treated group as compared with two to three weeks among the controls. This is what the drug is designed to do.

Decreased Applicants for Medical Schools

For the third consecutive year the number of individuals applying to U.S. medical schools has decreased, according to the Association of American Medical Colleges Datagrams. The total number of applicants to the 1959-60 class was 6 per cent less than the total number applying in 1956-57.

This took place despite the fact that undergraduate college enrollments continue to increase.

Future predictions of numbers of applicants to our medical schools should not be based on immediate past experience alone, the association cautions. We know, for instance that the young intellectual selecting a professional career 15 to 20 years ago was limited to medicine, law, and the clergy. Now, and in the future, vocational opportunities in professional, technical, and scientific fields offer him a wider choice and a similar standing in the intellectual community.

As a consequence, decreasing proportions of men with first level degrees will have an interest in medicine.

The reduced number of applicants to medical schools is not serious if, and only if, the *quality* and *variety* of the talent in the *accepted* applicant group is maintained and improved upon.

Nevertheless, this trend in decreasing numbers of applicants should not be taken lightly.

Cancer-Suppressing Drugs

Lederle Laboratories have been working on antifolic compounds since 1945 in hope of finding a product that suppresses leukemia and cancer. Aminopterin was the first of the more potent antagonists. It was followed by methotrexate in 1948 which was less toxic but just as active as aminopterin. Methotrexate (along with citrovorum factor) was given considerable publicity recently in a favorable article dealing with the treatment of cancer among patients in Kenya, Africa. The citrovorum factor (Leucovorin) is an antidote to the antifolic compounds and is useful in alleviating the toxic effects of these products. In 1951 Lederle synthesized dichloroaminopterin and dichloromethotrexate. The latter increased the survival time of mice with advanced leukemia by 75 per cent over methotrexate. We can expect to hear more of this drug in the future.

"A Rose by Any Other Name . . ."

Seditives and tranquilizers have many synonyms: The latest is calmative agents.

Travel Risks

Catastrophes are accidents in which five or more persons are killed. In the first half of 1960 they were responsible for 600 deaths in the United States. Many involved plane crashes and the greatest single disaster of the period was the plane that exploded in flight near Tell City, Ind. Approximately 15,000 died in auto accidents during the same period, a grim reminder that air travel is not quite so risky as many believe.

Portable Air Cleaner

A portable electronic air cleaner that removes airborne pollen, dirt, and bacteria may provide relief for patients with allergies at home or on vacation. This suitcase unit, according to the Minneapolis-Honeywell Regulator Company, removes irritants as small as one two-and-a-half millionths of an inch. It can be plugged into any outlet and operates on no more power than that required for a 40-watt light bulb.

Regulating Sale of Folic Acid

The FDA has proposed regulating the sale of vitamin preparations containing folic acid in more than 0.4 mg. or 400 micrograms per daily dose after March 1, 1961. Thereafter it would be available only by prescription, except in smaller amounts, provided it is safe.

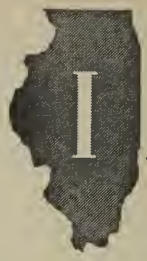
Hydrocortisone for Emergency Bag

Patients on steroid therapy are liable to acute adrenal insufficiency when exposed to stress. This occurred to three asthmatics when they developed pneumonia. One failed to respond to supportive therapy (prednisolone), according to a report in The Lancet (July 30, 1960). The author mentions several patients with rheumatoid arthritis who were having long-term cortisone treatment and died of pneumonia accompanied initially by only slight symptoms.

The lesson: Carry an ampule of hydrocortisone in the emergency bag and use it in these patients when they collapse or vomit.

Men are often capable of greater things than they perform. They are sent into the world with bills of credit, and seldom draw to their full extent. — Walpole

ANNOUNCEMENTS



Blue Shield Plans conference

Arthur S. Flemming, Secretary of Health, Education, and Welfare, will address the Annual Program Conference of Blue Shield Plans October 10-11 at the Drake Hotel in Chicago. His subject will be "Voluntary Health Plans Today and Tomorrow." More than 300 Blue Shield Plans physician-trustees and executives, as well as state and local medical society officers and secretaries, are expected to attend.

The two-day conference has as its theme "The Essentials of Leadership." Leaders in industry and American medicine are being invited to participate.

The national association stated that the October conference will replace the Blue Shield Professional Relations Conferences normally held each February.

APHA annual meeting

The American Public Health Association will hold its annual meeting in San Francisco October 31-November 4. About 60 related organizations will hold meetings during the week.

Among principal topics on the program are radiological health, health effects of food additives, and genetic and environmental aspects of public health. Several sessions will be devoted to discussion of medical care programs and plans.

Registration is open to nonmembers as well as members of the APHA and its related organizations.

A symposium on man's changing physical, chemical, and biological environment will be held October 31.

The Sedgwick Memorial Award and the Albert Lasker Awards will be presented.

Scientific sessions and scientific and technical exhibits are scheduled for the Civic Auditorium. Other sessions will take place at the Sheraton-Palace, Whitcomb, and Jack Tar hotels.

For further information address the Association at 1790 Broadway, New York 19.

State anesthesiologists to meet

The fall meeting of the Illinois Society of Anesthesiologists will be held in the Boulevard Room of the Sheraton-Towers Hotel, Chicago, on Saturday, September 17. The scientific sessions will begin at 2:30 p.m., recess for cocktails and dinner, and resume at 8 p.m.

The program is as follows:

"Anesthetic Management of Respiratory Insufficiency," Ruth Mansfield, M.D., Brompton Hospital, London.
"Halothane in General Surgery," Rudolf Frey, M.D., University of Gutenberg, Germany.
"Problems of Anesthesia in Central Europe," Dr. Frey.

Rhinologic society meeting in Chicago

The American Rhinologic Society will hold its annual meeting at the Belmont Hotel, Chicago, October 8. Physicians are invited.

The guest of honor and one of the afternoon speakers will be Dr. Henry L. Williams of the Mayo Clinic, Rochester, whose subject will be "Thirty Years of Experience in Rhinology." The dinner address, "Fifty Years of Medical Practice," will be given by Dr. Morris Fishbein.

Participants in a symposium on "Nasal Pressure Tests" will be Drs. Maurice H. Cottle, Chicago; David S. Hacker (Ph.D.), Evanston; Manuel Wexler, Los Angeles, and Charles J. Finn, Milwaukee. A symposium on "Choanal Atresia" will be presented by Drs. Francis H. McGovern, Danville, Va.; G. Slaughter Fitz-Hugh, Charlottesville, Va., and Henry H. Beinfield, Brooklyn.

Other afternoon speakers and their subjects: "Implant Materials — Compatabilities — Antigenicities," Drs. James A. Dingwall, Squibb Institute for Medical Research, New Brunswick, N.J. "Review of Reports on Lyophilized Bone and Cartilage," Dr. Raymond L. Hilsinger, Cincinnati. "The Comparative Anatomy of the Nose," Dr. Stuart Smith, Denver. "Hormones in Rhinology," Dr. Aubrey G. Rawlins, San Francisco.

Program of postgraduate courses

The programs for the two postgraduate courses of the Chicago Medical Society for general practitioners and specialists, October 17-21 and October 24-28, have been completed. A question and answer period ends each half-day session. Subjects and speakers are as follows:

Modern Diagnostics

Monday

Does the Virus Laboratory Have a Role in Practical Diagnostics? Marc O. Beem
Diagnostic Aids in Rheumatic Fever and Arthritis, Max Montgomery
Goitrous Cretinism, Sheldon Berger
Early Recognition of Intestinal Defects in the Newborn, Heyworth N. Sanford
Celiac Disease, Paul A. di Sant'Agnese
Diagnosis of Fibrocystic Disease of Pancreas, Paul A. di Sant'Agnese
Convulsive Disorders in Childhood, Louis D. Boshes
Office Diagnosis of Congenital Heart Disease, Benjamin M. Gasul
Recognition of Renal Disease in Childhood, Aaron Grossman
Malignant Disease in Childhood, Max Borovsky
What Children Should Be Referred to the Psychiatrist, Marvis Schwarz

Tuesday

Differential Diagnosis of Pruritis, Arthur L. Shapiro
Cutaneous Manifestations of Systemic Disease, Theodore Cornbleet
Pigmented Cutaneous Lesions, Allen L. Lorincz
Superficial Fungus Diseases, Irene Neuhauser
Deep Mycotic Infections, Tibor Benedek
The Venereal Disease Boomerang, Franklin R. Fitch
Hoarseness, Stanton A. Friedberg
Obstruction of the Airways, Albert R. Andrews, Jr.
Hearing Problems, Richard E. Marcus
Office Diagnosis of Glaucoma, Harold S. Feinhandler
Lesions of Common Interest Seen with the Ophthalmoscope, Stefan Van Wien

Wednesday

Panel: Problems of Lesions of the Branches of the Aortic Arch, Benjamin Boshes, Moderator
Clinical Significance of Raynaud's Phenomenon, David I. Abramson
Peripheral Ischemia, Frank V. Theis
New Concepts of Venous Stasis, Geza de Takats
Recognition of Bone Tumors, Harvey White
Orthopedic Problems in Athletes, Bruce J. Brewer
Principles Involved in Both Bone Fractures of the Legs, Carlo Scuderi
Injuries of the Hand, Allen F. Murphy
Shoulder Pain, Donald S. Miller

Thursday

Diagnosis of Prostatic Carcinoma, Jerrold Widran
Recognition of Treatable Renal Hypertension, Vincent J. O'Connor, Jr.
Roentgenological Diagnosis of Renal Disease, Jerome Nadelhaft
Significance of Urine Sediment Abnormalities, William F. Kellow
Diagnosis of Non-Obstructive Pyelonephritis, William McCabe
Diagnosis of the Paralyzed Bladder, Sherman E. Kaplitz
Detection of Intra and Peri Uterine Lesions by Means of Exfoliative Cytology, George L. Wied
Endocrine Aspects of Amenorrhea, Robert Ryan
Endocrine Disturbances in Gynecologic Practice, Jay J. Gold
Diagnosis of Vaginal Infection, H. Close Hesseltine.
Pelvic Tumors, A. E. Kanter

Friday

Diagnosis of Thyroid Disease, Theodore B. Schwartz
Serum Phosphatases in Diagnostic Medicine, William S. Hoffman
Significance of Serum Transaminase Abnormalities, Michael West
Amylase and Lipase Determination in the Diagnosis of Pancreatic Disease, Heinrich Necheles
Differential Diagnosis of Jaundice, Roy J. Korn

Modern Therapeutics

Monday

Treatable Strokes, Benjamin Boshes
Rehabilitation of Strokes (Essential Measures), Louis B. Newman
Surgical Management of Symptoms of Dystonia, Multiple Sclerosis and Cerebellar Disease, Irving S. Cooper
Surgical Management of Parkinson's Disease, Irving S. Cooper
Head Injuries, Eric Oldberg
Management of the Comatose and Stuporous Patient, Leonard Cardon
Role of Hypnosis in Therapy, Harold Rosen
Practical Treatment of the Chronic Alcoholic, John Cowen
Tranquilizers—Uses and Abuses, Harold Rosen
Energizers—Uses and Abuses, I. Spinka
Marriage Counseling by the Generalist, John P. Ham

Tuesday

Present Understanding of Clotting Mechanisms, Irving A. Friedman

Hemophilia and Hemophilia-Like States, Armand J. Quick
Thrombocytopenic and Thrombastenic Purpura, Stanley L. Leithold
Management of Hemorrhage from Fibrinolysis, John R. Tobin, Jr.
Hypercoagulability, Emanuel E. Mandel
Use of Anticoagulants, Norman B. Roberg
Diagnosis and Therapy of Megaloblastic Anemias, Paul Heller
Diagnosis and Therapy of Iron Deficiency Anemias, William R. Best
Diagnosis and Therapy of Hereditary Anemias, Aaron M. Josephson
Diagnosis and Therapy of Acquired Hemolytic and Refractory Anemias, Robert F. Schilling
Treatment of Polycythemia Vera, Louis R. Limarzi

Wednesday

Modern Therapy of Heart Failure, Craig W. Borden.
Modern Therapy of Bacterial Endocarditis, Paul S. Rhoads
Treatment of Arrhythmias, Richard Langendorf
Treatment of the Patient with Coronary Artery Disease, Clifford G. Pilz
Treatment of Shock, William J. Grove
Treatment of Cor Pulmonale, Aldo A. Luisada
Surgical Therapy of Mitral Valve Disease, S. Allen Mackler
Surgical Therapy of the Aorta—Aneurysms and Related Problems, Hushang Javid
Surgical Therapy of Congenital Heart Disease (Cyanotic), Egbert H. Fell
Surgical Therapy of Congenital Heart Disease (Acyanotic), Egbert H. Fell
Selection of Adult Patients for Cardiac Surgery, Ormand C. Julian
Present Status of Antibiotic Therapy, Harry F. Dowling
Resistant Organisms, Alvin Somberg

Thursday

Present Status of Antibiotic Therapy (cont'd), Harry F. Dowling
Treatment of Meningitis, Harold W. Spies
Diagnosis and Treatment of Bacteremic Shock, Craig W. Borden
Pseudo-Membraneous (Staphylococcal) Enterocolitis, Sidney Cohen
Genetic Basis of Disease, Sheldon C. Reed
Treatable Inborn Errors of Metabolism, Ira M. Rosenthal
Genetic Counseling, Sheldon C. Reed
Therapy of Inoperable Carcinoma, David A. Karnofsky
Therapy of Leukemia and Lymphoma, David A. Karnofsky

Friday

Oral Hypoglycemic Agents, Morton Smith
Treatment of Diabetic Coma, Noah B. Levin
Diagnosis and Treatment of Hypoglycemia, Theodore B. Schwartz
Disturbances of Calcium Metabolism, Gerald A. Williams
Adrenal Cortical Hyperfunction, Jay J. Gold
Current Status of the Treatment of Thyroid Disease, Ervin Kaplan

The registration fee of $75 for each course, which includes luncheon, morning and afternoon refreshments, and a booklet summarizing the lectures, should be sent to the Committee on Postgraduate Education, Chicago Medical Society, 86 E. Randolph St., Chicago 1.

Illinois GP meeting in Chicago

The Illinois Chapter of the American Academy of General Practice will hold its annual meeting at the Morrison Hotel during the week beginning September 26. The Congress of Delegates will gather for the first session on Monday afternoon and continue through Tuesday morning. The scientific assembly, for which 10 hours of Category I credit will be given, begins Tuesday afternoon and ends Thursday morning. The program includes:

Tuesday

Diverticulosis and Diverticulitis of the Colon, Charles W. Mayo, M.D., Rochester, Minn.
Management of Osteoporosis, James K. Martins, M.D., Eleva, Wis.
Twenty-five Years Experience with Pancreatitis, J. G. Probstein, M. D., St. Louis.
Treatment of Mongolism and Other Retardation, Henry Turkel, M.D., Detroit.

Wednesday

More Effective Management of Herpes Zoster, Richard M. Oliver, M.D., Chicago.
Emotional Aspects of Everyday Practice, William F. Sheeley, M.D., Washington, D.C.
Practical Considerations in Pediatric Respiratory Infection Management, H. V. Kuder, M.D., Indianapolis.
The Surgical Management of Inguinal Hernia, Leo M. Zimmerman, M.D., Chicago.
Current Concepts in the Treatment of Burns, Robert Allison, M.D., Warrenville, Ill.
Use of the Brown Dermatome, George Bordenave, M.D., Geneva, Ill.
Pathogenesis and Treatment of Thromboembolic Disease, Eugene E. Cliffton, M.D., New York.
Treatment of Liver Failure, Keith S. Henley, M.D., Ann Arbor.
Recent Advances in the Medical Management of Alcoholism, Fred E. Lawrence, M.D., Indianapolis.
A Rational Approach to Diagnosis and Treatment of Vulvo-Vaginitis, Paul R. Kearns, M.D., Statesville, N. C.

THURSDAY

Acute Abdomen, Manuel E. Lichtenstein, M.D., Chicago.

Panel Discussion: Newer Developments in the Treatment of Pulmonary Disease, Edwin R. Levine, M.D., Chicago, Moderator.

Seminar-discussion course in emotional disorders

The Mental Health Committee of the Illinois Academy of General Practice is sponsoring its second annual seminar-discussion course, "Office Management of Emotional Disorders." It will meet from 10:30 a.m. to noon on the first and third Wednesdays of each month from September 1960 through June 1961 at the Lutheran General Hospital, 1775 Dempster St., Park Ridge.

The discussions will be moderated by Samuel Liebman, M.D., clinical assistant professor of psychiatry at the University of Illinois College of Medicine. They will cover such areas as normal emotional development, the unique position of the physician in our society, interviewing techniques, psychotherapy, and case presentation. Category II postgraduate study credit may be earned by Academy members.

Physicians may register now for the first portion (Sept. 7, 1960-Jan. 18, 1961), second portion (Feb. 1, 1961-June 21, 1961), or for the entire course by sending $30 for each portion to Bertram B. Moss, M.D., Chairman of the Mental Health Committee of the Illinois Academy of General Practice, 14 E. Jackson Boulevard, Chicago 4. Checks should be made payable to the I.A.G.P.

Allergy forum

The annual meeting of the Midwest Allergy Forum will be held at the Penn Sheraton Hotel, Pittsburgh, October 22 and 23. The program will include a panel discussion on chronic urticaria, drug allergy, and repository therapy in addition to presentations on bronchial asthma.

International College of Surgeons meeting

United States and Canadian sections of the International College of Surgeons and the Manitoba Medical Association will hold their annual meetings together in Winnipeg, September 28-29 at the Marlborough Hotel. The two-day scientific sessions will include addresses on jaundice, plastic surgery, cancer of the throat, blood, bone fractures, and diseases of the esophagus.

Among co-chairmen of the special sessions are Drs. John Lundy, Chicago, anesthesia; William J. Blackwell, Chicago, obstetrics and gynecology; and Edward L. Compere, Chicago, orthopedics.

Surgeons outside of the United States and Canada who will attend include Prof. A. Mario Dogliotti of Turin, Italy, president-designate of the International College of Surgeons; Mr. Vivian Bartley Green-Armytage, England; Prof. José Soler-Roig, Barcelona; Prof. Bernhard Zondek, Jerusalem; and Mr. Patrick Wensley Clarkson, England.

Symposium on clinical chemistry

The Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic Foundation, is offering a symposium on advances in Clinical Chemistry Methods, November 9 through 11 in the North Clinic Building.

It should afford an unusual opportunity for the clinical chemist and clinical chemistry laboratory supervisor to learn of the latest developments in electrophoresis, chromatography, and pH.

The registration fee of $30, except for interns and residents who will be admitted free by prior arrangement only, may be sent to Education Secretary, The Frank E. Bunts Educational Institute, 2020 East 93rd St., Cleveland 6.

Dermatological society essay contest

The Chicago Dermatological Society is offering $500 for the best unpublished essay on some phase of dermatology or in the fundamental sciences relative to a dermatologic problem. A second prize of $300 and a third prize of $200 will also be awarded. The purpose of this contest is to stimulate young physicians and other young scientists in research study on the structure, functions, and diseases of the skin.

Competition is open to members and accredited guests of the Chicago Dermatological Society and those scientists in the Middle Western states sponsored (in writing) by a member.

Three copies of each manuscript together with illustrations, charts, and tables are to be submitted to the secretary of the society not later than Feb. 15, 1961.

Essays are to be judged on (1) originality of ideas and findings; (2) potential importance of the work; (3) clarity of presentation. This contest is intended as an annual one, but, if no paper worthy of a prize is offered in any year, the award may be omitted at the discretion of the committee.

The results of this contest will be announced at the meeting of the society in March of 1961.

Further information may be obtained from Frederick J. Szymanski, M.D., Secretary, Chicago Dermatological Society, 55 E. Washington St., Chicago 2.

Cancer symposium

A panel symposium on "Radical Surgery for Cancer" will be presented by the Metropolitan Chicago Chapter of the American College of Surgeons at 8 p.m., September 22 in the John B. Murphy Memorial Auditorium, 50 E. Erie St., Chicago. The moderator will be Dr. John M. Waugh, professor of general surgery, Mayo Foundation, Rochester.

Panel speakers and their subjects are Dr. Daneley Slaughter, associate professor of surgery, University of Illinois College of Medicine, "Cancer of Head and Neck"; Dr. Jerome A. Urban, instructor in surgery, Cornell University Medical School, "Cancer of the Breast"; Dr. Peter Rosi, associate professor of surgery, Northwestern University Medical School, "Cancer of the Colon"; Dr. Alexander Brunschwig, clinical professor of surgery, Cornell University Medical School, "Pelvic Cancer." A question and answer period will follow.

Residents and interns are invited.

A dinner at Harding's Restaurant will precede the meeting, and a business meeting will follow it. Phone number during the meeting is MOhawk 4-4050.

New date for medical writers' meeting

The American Medical Writers' Association annual meeting dates have been changed to November 18 and 19. The meeting will be held at the Morrison Hotel in Chicago. Two panels, one on "Information, What It Is and How It's Used," and the other on "Modern Aids to Medical Communication," will make up the first day's program, and the second day there will be workshops on writing.

Medicine on postage stamps

The United States has issued two four-cent postage stamps of medical interest.

One, "The American Woman" stamp, includes an arts and industry panel. The central figure is a caduceus representing about a half million physicians, nurses, and medical researchers.

The other is an "Employ-the-Handicapped" stamp showing a man in a wheel chair operating a drill press. It was issued August 28 and commemorates the fortieth anniversary of Federal aid to the physically handicapped.

Among other recent issues of postage stamps of medical philatelic interest are:

Belgium — Seven anti-tuberculosis stamps show Belgian folklore festivals and peace themes.

Brazil — A 2.50cr stamp marks the fiftieth anniversary of the discovery of the blood fluke, *Schistosoma mansoni,* by Dr. Piraja da Silva.

Costa Rica — The San Juan de Dios Hospital is pictured on one of a set of stamps honoring the 300th anniversary of the birth of St. Vincent de Paul.

Czechoslovakia — A 30h stamp honors the Red Cross.

Germany (East) — Five stamps picture medicinal plants.

Germany (West Berlin) — A stamp commorates the fiftieth anniversary of the death of Dr. Robert Koch, bacteriologist.

Guinea (Republic) — A five-value set promoting national health shows various medical and surgical procedures.

Netherlands — Two stamps commemorate the International Mental Public Health Year. One portrays J. L. C. Schroeder van der Kolk, anatomist and psychiatrist, and the other Joseph Weir, Dutch humanist and writer on mental diseases.

New Zealand — Two annual health stamps feature native birds.

Norway — Two flower stamps have surcharges for the benefit of the Norwegian Women's Public Health Association and Norwegian National Tuberculosis Association.

Pakistan — Two stamps commemorate the centenary of the Red Cross.

Russia — A 40k stamp marks the centenary of the birth of G. N. Gabrichevsky, Russian bacteriologist.

Switzerland — Four publicity stamps include a tribute to the international "Fight Against

Cancer" and to the fiftieth anniversary of the Swiss National League for Cancer Control.

Turkey — Four postal tax stamps show a woman physician examining a child.

ACP course in cancer

The second postgraduate course of the American College of Physicians, "Cancer and the Internist," will be held October 10-14 in the Auditorium, Memorial Center, Sloan-Kettering Institute for Cancer Research, 444 East 68th St., New York 21. The fee for members is $60; for nonmembers, $80. Director for the course is Rulon W. Rawson, M.D.

The third course, "Electrocardiography," will be presented November 7-11 at the University of Utah College of Medicine, Salt Lake City, under the direction of Hans H. Hecht, M.D.

Scientific instrument exhibit

Physicians interested in the latest medical equipment may wish to attend the Chicago Apparatus Company's annual Scientific Instrument Exhibit at the Edgewater Beach Hotel, Chicago, September 22 and 23. Thirty-six manufacturers will be displaying their latest developments in chemicals, centrifuges, automatic analyzers, spectrophotometers, and pH equipment. Many of these are to be shown for the first time.

Nutrition Conference

The annual Nutrition Conference, sponsored by the Illinois Nutrition Committee and the Nutrition Committee of the Illinois State Medical Society, will be held October 7-8 beginning at 9 a.m. at the Illinois State University, Normal. Physicians and those in allied professions interested in nutrition are invited to attend. Dr. William J. McGanity, University of Texas at Galveston, will speak on "Prenatal Nutrition and Maternal Health"; Dr. Philip L. White on "Advertising Impact on the American Diet;" Dr. Herman F. Meyer, Chicago, on "Infant Nutrition"; Dr. James R. Wilson, Chicago, on "Tom Spies, Pioneer Medical Nutritionist," and Dr. George V. Turnbull, Evanston, will speak on "The Geriatric Patient."

Dr. Paul A. Dailey, Carrollton, is chaiman.

October clinics for crippled children scheduled

Twenty-four clinics for physically handicapped children in Illinois have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. Nineteen general clinics will provide diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing service. There will be other special clinics for children with cardiac conditions, rheumatic fever, and cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative service. The October clinics are:

October 5	Hinsdale, Hinsdale Sanitarium
October 7	St. James Hospital
October 11	East St. Louis, St. Mary's Hospital
October 11	Peoria, Children's Hospital
October 12	Champaign-Urbana, McKinley Hospital
October 13	Cairo, Public Health Building
October 13	Springfield, St. John's Hospital
October 14	Evanston, St. Francis Hospital
October 18	Belleville, St. Elizabeth's Hospital
October 18	Danville, Lake View Hospital
October 18	Quincy, Blessing Hospital
October 19	Alton (Rheumatic Fever), Alton Memorial Hospital
October 19	Chicago Heights, St. James Hospital
October 20	Elmhurst (Cardiac), Memorial Hospital of DuPage County
October 20	Flora, Clay County Hospital
October 20	Rockford, St. Anthony's Hospital
October 25	Effingham (Rheumatic Fever), St. Anthony Hospital
October 25	Peoria, Children's Hospital
October 26	Carrollton, First Baptist Church
October 26	Elgin, Sherman Hospital
October 26	Springfield p.m. (Cerebral Palsy), Memorial Hospital
October 27	Bloomington a.m. (General), p.m. (Cerebral Palsy), St. Joseph's Hospital
October 27	Mt. Vernon, Masonic Temple

Nothing is so fatiguing as the eternal hanging on of an uncompleted task.—William James

NEWS of the STATE

County

Cook

ELECTIONS. The Chicago Society of Allergy elected the following officers for the year 1960-61: Drs. Bert B. Schoenkerman, Milwaukee, president; Charles M. Jenkins, Chicago, president elect, and Abe Matheson, Chicago, secretary-treasurer.

APPONTMENT. Dr. George F. Lull, Chicago, has been appointed medical director for the Cook County Department of Public Aid. He will administer funds totalling $2.5 million per month, the costs of medical care for public aid recipients.

Dr. Lull served the Illinois State Medical Society from October 1959 to June 1960 as secretary-treasurer. He was secretary and general manager of the AMA from 1946-58, and assistant to the president during 1958. He had previously retired from the Army as Deputy Surgeon General with the rank of Surgeon-General.

ELECTED TRUSTEES. Dr. Raymond Firfer and Dr. Adam A. Niec are among five persons newly elected to the Board of Trustees of the Chicago Medical School. Both are graduates of the school.

NORTHWESTERN UNIVERSITY HEALTH CENTER. Cornerstone-laying ceremonies for the new million-dollar Searle Hall, student health center on the Evanston campus of Northwestern University, was held July 25.

The two-story building was made possible by an $800,000 gift from John G. Searle, vice president of the university's board of trustees and president of G. D. Searle & Co., Chicago medical research and pharmaceutical manufacturing organization.

Other university officials participating in the ceremonies were Dr. J. Roscoe Miller, university president, and Dr. Leona B. Yeager, director of the university's student health service.

The health center will contain outpatient clinical facilities and general offices on the main floor and a 44-bed infirmary on the top floor. The level below the main floor will contain a small dining room, nurses' lounge, special laboratory and classroom and storage space.

The entire building will be air-conditioned, with radiant ceilings for both cooling and heating. Construction is expected to be completed by early 1961.

A medical library containing a collection of references concerning health and psychologic problems of young adults will also be housed in the building and will serve also as a staff conference room. The library is the gift of Dr. Mary M. Ray of Wilmette, director of the outpatient department, and Mrs. John F. Dove of Lombard, her sister.

UNGER RESEARCH LABORATORY. Dedication of a special research laboratory bearing the name of Dr. Leon Unger was held August 7 in Denver at the Children's Asthma Research Institute. The institute is an affiliate of the free, nonsectarian Jewish National Home for Asthmatic Children. It is devoted to research in asthma and other allergic diseases. Dr. Unger is founder of the allergy clinic of the Northwestern University Medical School, where he is an associate professor of medicine. He is also attending physician at Wesley Memorial Hospital.

HONOR VETERAN STAFF. Thirty-five physicians who have served on the St. Francis Hospital medical staff for 25 years or longer were honored at a dinner given by the Sisters of St. Francis in July. The doctors have given their patients 1,157 years of service since they became members of the staff. All but Dr. I. H. Chilicott, who lives in California, attended.

The guests included Dr. A. R. Konle, Chicago, the second intern at St. Francis, who joined the staff in 1916. Several other physicians who interned at St. Francis are still on the staff: F. L.

McGrath, Evanston, and W. L. Waner, Skokie, since 1926; P. J. Kullman, Lincolnwood; and F. D. O'Donnell, Wilmette, since 1930, and Noel G. Shaw, Evanston, since 1932.

Other physicians honored are B. E. Fillis, Evanston, and L. R. Mee, Wilmette, 1917; T. E. Conley, Park Ridge, L. D. Minsk, Evanston, and J. T. O'Connell, Chicago, 1920; S. E. Brown and Mary H. Pope of Evanston; G. H. Irwin and J. L. Meyer, Chicago, 1926; H. H. Conley and M. W. Caveney of Park Ridge, G. J. Fitzgerald, the present president of the staff; E. J. Hynes, and F. T. O'Connell, Sr., Evanston, J. J. Mussil, Skokie, and I. Perrill, Chicago, 1927.

H. H. Engelhard, Golf, and L. A. Juhnke, Delavan, Wis., 1928; L. W. Mason, Winnetka, and Charles Pope, Evanston, 1929; L. J. Crowley, Evanston; R. M. Jones, and W. D. Mackenzie of Winnetka, 1930; F. W. Schacht, Evanston, 1931; C. W. Rainey, Glencoe, 1932; Clarence Minnema, Northfield, 1933; N. F. Leckband, Arlington Heights, 1934; and J. C. Bremner, Skokie, and A. C. Ledoux, Evanston, 1935.

Most of the doctors served in either World War I or World War II; several have been president of the staff or heads of departments and worked on staff committees over the years.

Grant for Research in Ophthalmology. Dr. Frank W. Newell, professor of surgery and chairman of the ophthalmology section, University of Chicago, has received a grant of $5,000 for research and research training in ophthalmology from Research to Prevent Blindness, Inc., of New York.

He is one of 11 doctors in medical schools throughout the country to receive such a grant. The organization was founded recently to support and stimulate research.

Knox

Galesburg Hospital Anniversary Program. The Galesburg State Research Hospital will observe the tenth anniversary of its establishment this fall with a special "Symposium on Biological, Psychological, and Sociological Research Approaches to Psychiatric Problems," to be held October 21 and 22 at the Hotel Custer in Galesburg. All members of the Illinois State Medical Society are invited.

Contributors to the symposium include the following physicians: C. Knight Aldrich, Franz Alexander, Percival Bailey, John D. Benjamin, Benjamin Boshes, Harry Garner, Roy R. Grinker, Harold E. Himwich, Franz J. Kallman, Heinz E. Lehmann, John J. Madden, Jules H. Masserman, Ralph Rabinovitch, and Jay T. Shurley. Also Ray Birdwhistell, Harry F. Harlow, August B. Hollingshead, Horace W. Magoun, and Martha Vogt, all Ph.D.'s.

Winnebago

Roland I. Pritikin, Rockford, was awarded a bronze plaque by the local chapter of Lions International for community service for the needy blind and partially sighted. This is an honor given to nonmembers, and only rarely.

General

Elections. Dr. Otto L. Bettag, Chicago, was re-elected Regent of the College of Chest Physicians for this district, and Dr. Darrell H. Trumpe, Springfield, was re-elected Governor.

Grants for research

The Journal has been carrying news items of various grants from the state and Federal governments. One reason why these items have been included is that we believe physicians are interested in knowing about the sources of support. There seems to be no end to money for research purposes. We will continue these monthly reports.

Plan promotion for Diabetes Week

The American Diabetes Association is offering organizational, educational, and publicity materials to county medical societies who have appointed chairmen of Committees on diabetes for their Diabetes Week programs scheduled for November 13-19. County medical societies wishing to receive this material should have their committee chairman write to Louis K. Alpert, M.D., Chairman, Committee on Public Education and Detection, American Diabetes Association, Inc., 1 East 45th St., New York 17.

State mental health centers get grants

Grants from the state totaling $1,206,000 for the fiscal year beginning July 1, 1960, have been made to 28 community mental health clinics and other special mental services. They are made from state and Federal mental health funds assigned for the purpose and represent an increase of $162,994.19 over 1959 grants.

Since 1953 the number of state-aided community mental health clinics has more than quadrupled. Eighty per cent of the total allocations to the community clinics are from these special state monies.

More than 11,500 patients were seen last year in these clinics, a 10 per cent increase over the number served the previous year. Of these, more than 1,000 were patients on conditional discharge from state hospitals.

Grants to Chicago area clinics:	
Chicago Board of Health	$41,000
Children's Memorial Hospital	32,750
Mary Thompson Hospital	20,000
Mercy Hospital	42,000
Michael Reese Hospital	47,000
Mount Sinai Hospital	17,500
Northwestern University	40,500
Other clinics, their locations, and grants:	
Alton, Madison County Mental Health Clinic	$40,000
Bloomington, McLean County Mental Health Center	50,000
Champaign, Champaign County Mental Health Clinic	55,000
Danville, Paris, Watseka, Eastern Illinois Mental Health Unit	46,500
Decatur, Mental Health Clinic — Macon County	48,500
East St. Louis, Mental Health Center of St. Clair County	45,000
Elgin, Fox Valley Mental Health Clinic	50,000
Joliet, Will County Health Department	33,500
La Grange, Southwest Suburban Mental Health Clinic	37,500
McHenry, Mental Health Center of McHenry County	38,750
Moline, Child Guidance and Mental Health Center of Rock Island County	50,000
Murphysboro, Southern Illinois Mental Health Clinic	30,000
Peoria, Mental Health Center of Peoria, Tazewell, and Woodford Counties	65,000
Quincy, Mental Health Center of Adams County	37,750
Rockford, Mental Health Clinic of Winnebago County	48,500
Springfield, Mental Health Center	72,000
Stickney Township Health District	24,750
Waukegan, Lake County Mental Health Clinic	42,500
Winnetka, North Shore Mental Health Clinic	36,000

Additional grants totaling $114,000 for special mental health services went to the following agencies:

In Chicago: Retarded Children's Aid, Hull House, for day center for young retarded adults, $30,000; Jewish Vocational Service for rehabilitation services to conditionally discharged patients from state mental hospitals, $18,000; Illinois Children's Home and Aid Society for psychiatric outpatient services for adolescents in residential program, $11,000; National Council of Jewish Women, The Thresholds, for a day center for the mentally ill, $10,000.

Peoria Council for Mentally Retarded Children for training program for pre-school and young adult mentally retarded $20,000; Illinois Department of Public Health for mental health film library, $5,000; Southern Illinois University, Carbondale, for community mental health plays program, $1,450; Illinois Department of Public Welfare for training grants and mental health education, $18,500.

Communities interested in grants for local clinics may obtain information by writing to Charles R. Meeker, Administrator, Community Mental Health Services, 403 State Office Building, Springfield.

Centralia selected for state institution

A new institution for the mentally retarded in Southern Illinois is to be constructed in Centralia, in Marion County.

It was authorized by the last General Assembly.

Twenty-two communities in 15 counties were surveyed in a nine-month period. Centralia was the unanimous choice of the study group. It is geographically centralized; an established junior college works in close cooperation with Southern Illinois University; a training school for professional nurses is being established at St. Mary's Hospital; medical staff on a consultation basis is available; its public schools are integrated; the city is an attractive one in which to live and the available locations meet all requirements.

Governor Stratton has also revealed initial planning for construction of up to three similar institutions elsewhere in the state.

State aids treatment centers for alcoholics

Nine agencies engaged in the treatment and rehabilitation of alcoholics, as well as research and education about alcoholism, will share state grants totaling $235,400 from the Division of Alcoholism, a three year old unit of the Illinois Department of Public Welfare. Seven of the grantees are agencies in Chicago, where about 175,000, or 52 per cent of the state's 335,000 alcoholics reside.

Sums of $20,000 were allocated to the Chicago Committee on Alcoholism and to Chicago's Alcoholic Treatment Center. The former offers

treatment to the alcoholic through Portal House, its outpatient clinic, drawing patients from business and industry. The latter is a 72-bed inpatient treatment center operated by the city of Chicago under the auspices of the Mayor's Commission on Rehabilitation of Persons. In its three years of operation the center has cared for more than 1,300 alcoholic men in its treatment program.

Harbor Light Center of the Salvation Army and the Chicago Christian Industrial League of the United Presbyterian Church, which work with skid row alcoholics, were granted $20,000 and $12,000 respectively.

Cathedral Shelter of the Episcopal Church was given $8,000. St. Leonard's House, a "halfway" house for alcoholic men just released from penal institutions and attempting to make their way back to normal life, was granted $9,450. It too is under the jurisdiction of the Episcopal Church.

Grateful House, a six-bed home for alcoholic women, was allocated $4,000. This facility, also a transition shelter, is the only one of its kind in Chicago. Its main support is contributions from individual members of Alcoholics Anonymous.

Four scholarship grants totaling about $9,000 were awarded graduate students at Southern Illinois University for research on alcohol-related problems to be reported in masters and doctoral theses.

All of these grants are in accordance with the original program outlined by the Illinois Commission on the Care of Alcoholics, according to Dr. Otto Bettag, state welfare director.

The alcoholism unit at Peoria State Hospital received $65,000 for its pilot project seeking answers to the effectiveness of the psychological approach in treatment and rehabilitation of a selected group of inpatient alchoholics. In Chicago the Warren Clinic at the Mental Health Centers of the Illinois Department of Public Welfare was granted $29,000. This agency, too, is psychiatrically oriented.

A sum of $39,000 was set aside for program development.

All grants to agencies are used primarily for the employment of more professional personnel, and to increase the scope and effectiveness of their work. The division is particularly interested in community projects.

Physician members of the board are Dr. John J. Madden, chairman, department of neurology and psychiatry, Stritch School of Medicine, Loyola University, and Dr. Clarence E. Boyd, Marion, consultant to the Veterans Administration and Anna State Hospital.

Illinois shares Federal research grants

Sixty-six grants totaling $21,987,153 to help build and equip additional health research facilities in 55 institutions in 30 states have been approved by the Public Health Service.

Illinois institutions will receive grants as follows:

Evanston Hospital Association	$66,378
University of Illinois, Urbana	74,425
University of Illinois, Chicago	3,750
Loyola University	521,700
Michael Reese Hospital and Medical Center	422,895
Total	$1,089,148

Deaths

Thomas B. Carney*, Chicago, a graduate of Loyola University School of Medicine, Chicago, in 1932, died July 10, aged 54.

Henry B. Delicate, Edwardsville, a graduate of Washington University School of Medicine, St. Louis, in 1924, died May 17, aged 61. He was on the staff of St. Elizabeth Hospital in Granite City.

Roger Truman Farley*, Chicago, a graduate of College of Medicine and Surgery (Physio-Medical), Chicago, in 1901, died April 23, aged 82. He was a member of the American Academy of General Practice, and affiliated with Jackson Park Hospital.

Joseph P. Graf*, Chicago, a graduate of Chicago Medical School in 1918, died July 24, aged 69.

Edward Kenton Lockwood*, Springfield, a graduate of Marion-Sims College of Medicine, St. Louis, in 1895, died May 13, aged 90.

Hiram B. Young, retired, Gurnee, a graduate of Rush Medical College, Chicago, in 1898, died July 6, aged 86.

**Indicates member of the Illinois State Medical Society*

BOOK REVIEWS



HANDBOOK OF NEUROLOGICAL DIAGNOSTIC METHODS. Fletcher McDowell, M.D., and Harold C. Wolff, M.D. $4.50. Pp. 201. Baltimore, The Williams & Wilkins Company, 1960.

From the combined interest and efforts of some 32 members of the Neurological Division of the department of medicine of Cornell University Medical College comes this manual. It is the product of 28 years of development with repeated revisions to include the ever-evolving concepts of form and function of the nervous system, especially as they apply to the various methods of examination. Neurologist, neurophysiologist, neuropathologist, neuroradiologist, neuro-ophtholmologist, neurotologist, neurosurgeon, neurochemist, electroencephalographer, and internist, each in his own fashion has contributed to this little volume in a way that leaves little doubt that man as a patient is viewed holistically.

There are 26 component interlinking areas beginning with titles such as: Eliciting a History; The Neurological Examination; Various Adjunctive Laboratory Examinations; Cornell Medical Index; Health Questionnaire; Evaluation of a Patient in a Coma; Management of a Patient with Head Injury; Coma; Delirium; Status Epilepticus; Ventilatory Failure; and ending significantly with a chapter entitled "Irreducible Minimum of Information Essential to an Intelligent Understanding of Disease of the Nervous System."

The manual, as described by Dr. Harold G. Wolff, a senior author, keeps pace with the usual traditions of teaching in that there is orderly, pedantic, stepwise procedure in learning techniques. The reader can hardly escape this organization and quickly recognizes the message.

This is one of the best manuals in neurologic diagnosis now available. It is the present finished product of the outgrowth of the educational concepts of an outstanding department in the neurologic discipline. Further revisions can be only minor ones, this handbook is so uniformly complete. I endorse this manual as a "must" for anyone in the general field of neurology.

Louis D. Boshes, M.D.

THE RELUCTANT SURGEON. John Kobler. $4.95. Pp. 359. Garden City, N.Y., Doubleday & Company, Inc., 1960.

An excellent book on the life and times of John Hunter. The author is a Saturday Evening Post editor who obviously spent many years of research on this odd eighteenth century medical genius. As physicians we are acquainted with the Huntarian principle, so let's demonstrate the quality of the book with this rather lengthy quote on the period rather than the man. It deals with William Cheselden, a talented surgeon who was famous for his skill at lithotomy. It was done without anesthesia, and speed was paramount.

"There was no operating theater. Any room in the hospital might be used, even a ward full of other patients. Only those who could not afford to be operated on at home went to hospitals.

"Brawny assistants bore in the patient, who

wore a loose nightgown. Under a window, in strong light, stood a table three feet high with a stool at one end. After administering a stiff draught of brandy or laudanum, the assistants laid the patient face up on the table, his torso kept higher than his head by layers of blankets. They drew his ankles back until they touched his buttocks and with strips of linen tied them to his wrists. They held his knees high and wide apart to expose the perineum—the area between the scrotum and the anus. One of the assistants produced a watch.

"He doffed his coat, rolled up his shirtsleeves, and lowered his massive frame onto the stool. In a pouch strapped to his side he carried five instruments—a catheter, or hollow tube, some ten inches long; a scalpel, its edges swathed in linen so that only the point would cut; forceps; a gorget, or grooved rod, for channeling the forceps into the bladder; a threaded needle. Close at hand was a jar of oil and bandages. As the assistants tightened their grip, Cheselden arranged his instruments in order of their use.

"He tried to find a word of comfort for his patient, and by his gentleness he robbed surgery of some of its horror. Occasionally, he wrought a miracle. Obliged once to open a child's bladder, he promised him a sweetmeat if he held perfectly still and made no outcry. The child never budged, and as soon as it was over, claimed his reward.

"Cheselden dipped the catheter in the oil to ensure smoother passage, and slipped it up the uretha, into the bladder. With the tip he probed for the stone. Finding it, he signaled an assistant to hold the catheter in place. He reached for the scalpel. Wielding it like a pen, he made a long, swift, vertical cut in the perineum. Through the incision he advanced the scalpel until, with his forefinger, he could feel the outline of the catheter above it. With the catheter to guide the scalpel, he cut straight into the bladder, the two instruments meeting. He returned the scalpel to his pouch and manually dilated the incision so that it could accommodate thicker instruments. He next inserted the gorget. The catheter, having served as guide and marker, went back into the pouch. Cheselden then slid the forceps along the gorget, into the bladder. The instant they made contact with the stone he withdrew the gorget. He opened the forceps inside the bladder, closed them upon the stone and extracted it.

"After suturing and dressing the wound, Cheselden examined the stone, memorizing its contours for future reference. He turned to the assistant with the watch. The assistant called out: 'Two minutes, forty seconds, sir.'"

T. R. VanDellen, M.D.

ELECTROCARDIOGRAPHY: PRINCIPLES AND PRACTICE. Ernest B. Zeisler, M.D. $12.50. Pp. 374. Illustrations. Chicago, Login Brothers, 1960.

This new text vigorously attacks the conventional concepts of electrocardiography and accentuates the admitted deficiencies of the Einthoven and Wilson concepts of the electropotential field of the heart within the human body. The author discards pervious theoretical considerations in favor of empirical interpretation of clinical electrocardiography, but he reproduces no actual electrocardiograms or pathologic observations for such empirical interpretation.

Diagrams of various rhythm disturbances are good, but they are not accompanied by the electrocardiograms from which they were derived. The style of writing is rather complex and ponderous. New terminology has been added. A fifth of the book is in the form of an appendix devoted to geometric and trigonometric analyses of electropotential conduction. References to opposing concepts of electrocardiography are thoroughly documented and constitute the outstanding feature of the book.

"Electrocardiography: Principles and Practice" will be of greatest value to the advanced electrocardiographer requiring a polemic to stimulate inquiry into the origin of his personal beliefs but will confuse more than educate the neophyte.

William H. Wehrmacher, M.D.

Chance favors the prepared mind.—Louis Pasteur

OFFICIAL BUSINESS

House of Delegates

THIRD SESSION
Thursday, May 26, 1960

The Third Session of the House of Delegates of the Illinois State Medical Society was reconvened at 8:15 a.m. President O'Neill presiding.

THE PRESIDENT: (Call to order) Will the chairman of the Credentials Committee inform the chair as to whether we have a quorum?

DR. SIBILSKY: Mr. President, we have a sufficient count registered and sufficient delegates certified to account for a quorum.

THE PRESIDENT: The next item is the roll call by the Secretary. Do you wish to move that this roll call be dispensed with and that the attendance constitute the roll call? (Carried)

THE PRESIDENT: What action do you wish to take with regard to the minutes of the previous session? (Minutes adopted)

THE PRESIDENT: We now come to the matter of the election of officers.

The first officer is the President-Elect, who, this year, comes from downstate. The chair recognizes Dr. Willard Fullerton.

DR. FULLERTON: I wish to place in nomination for President-Elect, Dr. Edward Hamilton.

THE PRESIDENT: The name of Dr. Edward Hamilton has been placed in nomination for the office of President-Elect. (Unanimously elected)

DR. HAMILTON: Mr. President and members of the House: I want to express to you my appreciation for election to this position. I appreciate the responsibilities that go with the honor that you have accorded me.

Based on attending the meetings of the Illinois State Medical Society for more years than I care to admit, and twenty-five to thirty years in the House or the Council, I think that I am familiar with most of the problems of this society. I am sure that you know that I will take an active interest and do what I think is best at all times for the medical profession of Illinois and for the citizenry of Illinois.

I would like to digress for just one second and congratulate the speaker and the president for the excellent manner in which he is conducting the meetings. This has verified an expert opinion that I have expressed for many years, that there is no reason why we need a Speaker of the House when we have such wonderful ability as that which has been indicated by Dr. O'Neill.

Again I thank you and promise you that during the next two years, if the flesh holds out, that the spirit will be willing and the only thing that I will put ahead of the Illinois State Medical Society is my family.

Elections

Officers
(Unanimously elected)

First Vice President — Dr. Andrew Brislan, Chicago
Second Vice President — Dr. Clinton Swickard
Secretary-Treasurer — Dr. Jacob E. Reisch, Springfield

Councilors

Third District — Dr. J. Ernest Breed and Dr. Theodore LaBoy succeeding Drs. Harry J. Dooley and Earl H. Blair
Sixth District — Dr. Newton DuPuy, succeeding himself
Ninth District — Dr. Burtis E. Montgomery, succeeding himself
Tenth District — Dr. Willard Fullerton, succeeding himself

Delegates to the AMA
(Two year terms — effective Jan. 1, 1961)

Dr. Morris M. Kulchen, succeeding Dr. Percy Hopkins
Dr. Leo P. A. Sweeney, succeeding himself
Dr. Carl F. Steinhoff, succeeding himself
Dr. Harry Mantz, succeeding himself
Dr. Burtis E. Montgomery, succeeding himself

Alternate Delegates to the AMA
(Two year terms — effective Jan. 1, 1961)

Dr. H. Close Hesseltine, succeeding Dr. Maurice M. Hoeltgen
Dr. R. C. Oldfield, succeeding Dr. Allison L. Burdick
Dr. Norris J. Heckel, succeeding himself
Dr. Paul Dailey
Dr. Lester S. Reavley, succeeding himself

Standing Committees

Grievance Committee: Dr. Percy Hopkins and Dr. Victor V. Rockey (Three year terms)
Committee on Medical Education and Hospitals: Dr. Kenneth C. Johnston, Dr. Ward Eastman and Dr. George F. O'Brien (One year terms)
Medico Legal Committee: Dr. George C. Turner and Dr. Charles Allison (Three year terms)
Committee on Medical Testimony: Dr. Leo P. A. Sweeney and Dr. Harry D. Nesmith (Four year terms)
Committee on Pre-payment Plans and Organizations: Dr. E. Lee Strohl (Three year term)
Committee on Medical Benevolence: Dr. F. M. Nicholson (Three year term)

DR. FULLERTON: In connection with the District Constitutional Committees, of which there are three for each district and the members of which are selected by the respective district councilors, were approved by the district caucuses last night and I therefore move their election by this House. (Carried)

THE PRESIDENT: The next item on the agenda has to do with the fixing of a per capita assessment for 1961. The chair now recognizes the Chairman of the Council, who usually makes the recommendation, Dr. Montgomery.

DR. MONTGOMERY: You have in your hands a proposed budget for the Illinois State Medical Society for the period May 1, 1960 to April 30, 1961, which is the ensuing fiscal year.

You will note there are certain items on here which are non-recurring expenses, which have occurred during the reorganizational program and which will not be in a subsequent budget. You will notice that these items have been projected and then extracted. This leaves an estimated annual deficit, at the rate we are now going, of $214,900.

At the meeting yesterday this House passed the recom-

mendation of the Reference Committee that the dues be assigned according to the need. After consultation with Mr. Richards, our Executive Administrator, and the Council, as well as all of those people who have to do with the estimation of the amount of money needed to do a good job in this organization, we set up the budget as you have it here.

I am sorry that we cannot give you too much of a detailed report with respect to these things but then I can assure you that these are fairly close estimates.

Next year we hope to have before this House when it meets a complete itemized suggested budget and I hope that you will bear with us during this process of change so that we can actually get the show on the road and do the job as it should be done.

It is the recommendation of the Council to this House that the dues be raised this year an additional $30.

I so move. (Seconded)

THE PRESIDENT: It has been moved and seconded that the dues this year be raised $30. Is there any discussion?

DR. MONTGOMERY: I will try to explain that. That would make the total state dues $80, twenty of which goes to the American Educational Fund of the A.M.A.

Now, in this state we have approximately nine thousand dues-paying members, although our roll states that we have somewhat over ten thousand registered doctors. Of course, there are many of those who are not dues-paying members. If you figure the deficit that has been estimated here, you can see that it is going to take a certain increase in dues.

I have dues figures from all the states in the union and the most comparable state to us is Pennsylvania. Pennsylvania at the present time has a dues structure of $60, which is alloted to the state society for the carrying on of its work. Out of that, there is one three-dollar item that goes to Benevolence and another three-dollar item that goes to the Educational Fund; this leaves Pennsylvania $54 on which to operate its society.

There are 38 employees in the state society, including all of the field officers. If you want some information as to the reorganization in that state, I can say to you that they have gone through the same process that we are going through now but it happened to them about 10 years ago.

Now, taking $20 from the $80, this would leave an operating expense for our society of $60. Two dollars of this goes to benevolence, leaving $58 per member of operating expense.

If there are any questions, we have Mr. Richards, our legal counsel and others here who I am sure will do their best to answer them.

THE PRESIDENT: Before calling for discussion, I would like to request that you stick to the discussion on the motion, which has to do with increasing the dues to $30 this year.

DR. HEERENS: I wish to state, first of all, that I am quite anxious that the House of Delegates support the new program with Mr. Richards heading it. I have known Mr. Richards for a number of years through his public relations efforts and also while he was state secretary in Pennsylvania.

Of course, when I go back to my county medical society, mention our new program and then also the fact that we are going to get hit with an increase, I don't know what will happen. We already are paying a total of $170. This will mean that each member of our society will pay a total of $200 per year.

Now, in figuring the $30, this produces $276,000. Further, the deficit for this year, which includes purchasing $39,000 of this capital equipment, which will not recur, produces a deficit of $254,400. This means that there is approximately $20,000 that is not accounted for in the budget.

Secondly, with the projected annual deficit of $214,900, with the non-recurring expenses eliminated, we find that this $276,000 as an annual gimmick would produce about $60,000 in excess.

I am certainly for supporting Richards and his program but I am against anticipating excesses over income on a basis like this.

I would certainly like to see this modified. I will not make a motion but I would like to see the AMEF fund suspended temporarily, until we can get our organization going, and use this $20 to supply part of the money that Bob Richards needs to provide one of the bulwarks against socialized medicine. I think that we deserve this after a period of years of having a compulsory tax to support the medical schools.

I would prefer that this $20 be used to support the program that we want and which we need in Illinois so badly and perhaps it could be put on the statement as a voluntary contribution.

Therefore, I would merely like to make that suggestion, sir.

DR. SAXON: I certainly agree with the previous speaker that the tax, insofar as our state society is concerned, should probably be on the basis of actual need rather than be accumulative and sit in our treasury. We do not want to run short of meeting the requirements of our program but, if I am led to believe properly, we are going to incur not just $30 worth of expense—there will be a good deal of additional expense in attacking a socialized medical program on a more forceful basis. I dare say that when the program gets in full swing the tax probably will again have to be increased or an additional tax collected by the society.

The availability of funds to be used for political purposes, whether they are collected directly by the society or some society sponsored organization, must also be considered.

I would propose and I would agree that even though our medical schools are always in need of money, that I have never seen a medical school in all my years of learning that has ever gone poorly endowed. I am sure that there is need but I think that the contributions that medicine itself makes are probably minimal to the endowments that are made to teaching institutions.

I think that we should shim down our expenses because of the dire need for conserving the practice of medicine for those who would practice medicine in its best manner.

DR. WHITING: I would like to speak in favor of the proposed increase in dues to finance the organization.

First of all, with reference to the suggestion that the donation to the AMEF be used for expenses of the Society, I recall with considerable pain the difficulty which was incurred in initiating this program in this House about eight years ago. I recall also that for several years after that, in reference committee, Winnebago County was in opposition to the continuance of the donation to the AMEF.

It strikes me that the doctors of medicine who make up the Illinois State Medical Society are as well able to contribute to the expenses of their operation as are those men who make significant contributions to union funds throughout each year.

Although I recognize the fact that the dues of the society are of significant size, at the same time I also feel that it is our obligation to support all of the activities of our state society and to promote its efforts to be effective as representing doctors of medicine in this state.

Although it is true that there may be some increased needs in the future, a careful evaluation of the budget as it has been presented would indicate that the amount of money requested is not necessarily large. Even though I also will go back to my county society with some fear, I do feel personally that the additional increase of $30 is desirable for this state society.

THE PRESIDENT: May the chair just impart this information impartially: you understand, of course, that an increase in dues would be effective on January 1, 1961 and that this is May of 1960.

DR. BORNEMEIER: I would like to speak a word or two about the $20 donation for the American Medical Education Foundation. The Medical Society of the State of Illinois has been held in very high esteem all across the

country because we initiated the strong support to a voluntary fund to the medical school. I have no idea how much pressure has been brought upon medical schools to accept federal aid and accept federal subsidies, but then the $20 that Illinois has contributed and the following suit of many of the other states throughout the country has been one of the most tremendous things keeping the medical schools free.

I firmly believe that the doctor of medicine can certainly pay $20 a year to support the medical schools, which is the place where we learn the practice of medicine and I think, if at all possible, that it should not be dropped.

I think that Illinois has held its head high for a great many years because we have been the leader in the field to contribute to A.M.E.F.

DR. VAUGHN: I feel likewise, that we can all afford to keep up this AMEF donation. It has been a great thing. Our medical schools are in trouble and this helps out the medical schools to a very large extent. The money that you give will be earmarked for a medical school.

I know that we would all like to see our medical school kept going and so I think that it would be a mistake for us to discontinue this contribution at this time.

DR. BELL: I was on the committee last year which recommended higher dues. I think that this probably will take more than we think it will. I would rather go back to my medical society and ask for one raise rather than three successive raises. I think that any hampering program will be detrimental to the welfare of every doctor in this state.

I would also like to add that if the individual members in this state had a real individual interest in the society that they would pay more attention to its activities.

DR. ACKLEY: I would like to say that not only should the budget be supported but in addition, we should contribute something to the legislative program of the state. It seems as though we could probably make an additional increase this year and also probably next year to take care of the matter.

DR. SWEENEY: I have broken this down so that I can understand it a little better and I find that if I worked two hundred days a year that $20 would amount to ten cents a day, and $30 to fifteen cents a day.

DR. CALLAHAN: I would like to speak for the downstate point—that our citizens here in Chicago and, I think, downstate referred to only part of what our contribution to the educational fund is doing. We think in terms of those funds going to the schools from which we received our education.

I would also like to call your attention to the continuing education which comes to us all the time in that our essential medical research is sending us the tools that you and I are using in our everyday work, and which is contributing both to your and my benefit in connection with dealing with our patients.

I think that all you need do is to think over the three outstanding reports that came to you yesterday in connection with the help of your patients today.

Therefore, I speak for the retention of our educational funds.

DR. GIBBS: I would also like to speak in favor of the raise in dues because I know that much of it is also being put into channels to fight the enemies of medicine.

DR. HOPKINS: I would like to make the observation that this House of Delegates, as well as the A.M.A., has repeatedly made the announcement and demonstrated its willingness to support the philosophy of voluntary contribution to the medical schools as a means of obviating the need for federal grants.

I think that it could be interpreted in some circles, if this support were withdrawn and this policy changed, as a falling way from our position which we have previously adopted and previously carried on through the years.

I would point out another thing—that one should make comparisons so far as actual dues are concerned. The amount of money that we are paying now, in our effort to stay alive in the free enterprise system with the private practice of medicine, is insignificant when compared to the dues that some people who are anxious to exterminate us are paying.

Therefore, I would like to speak in favor of this motion.

DR. HEERENS: My discussion merely had to do with raising some alternatives and it appears that the sense of this group is one of supporting the dues increase. We are certainly in favor of the new look in the Illinois State Medical Society and hope that greater efficiency and progress will result.

Mr. Chairman, I would like to move that we set $30 as the dues raise for the next year. (Seconded)

THE PRESIDENT: Wait a moment now. We expect to give you plenty of time for discussion. However, if you are ready for the question, then you make a motion to close debate on the matter.

DR. SAXON: I would like to have one item cleared. I have reference to Dr. Fowler's suggestion as of yesterday relevant to an organization for the purpose of combatting socialism. I don't know what the legal status of this would be, but in talking with Dr. Fowler, he pointed out that California adds an additional ten dollars to its dues to be designated for this particular fund. I believe that legally money collected by way of dues to the state society cannot be used for such a purpose. If I am wrong, I would like to be corrected.

On the other hand, if this is true, I would like to propose that to initiate more actively this program, we add a separate item to whatever figure the House may see fit, to be collected specifically and designated for this other arm of the state society.

THE PRESIDENT: That is not a motion. Is there any further discussion?

DR. PAUL W. SUNDERLAND: I move the question. (Seconded)

THE PRESIDENT: It has been moved and seconded that we pose the question. (motion carried)

THE PRESIDENT: We are now going to vote on the motion to increase the dues to thirty dollars. (Carried)

THE PRESIDENT: May the chair express a personal viewpoint by saying that I am proud of the evidence of profound thinking which has been expressed by this House this morning. You have realized something that was necessary and you have taken step to implement it. It is an honor to be the head of this House on this occasion and I want you to know it.

We will now return to the item of awarding of the awards for the scientific portion of the program and the chair will recognize Dr. Mason in this connection.

(The awards in connection with the scientific program were then read by Dr. Mason.)

Awards

A. For Original Work
  Gold Medal: Title: The Crico-Arytenoid Joint
    Exhibitors: Hans von Leden and Paul Moore
  Silver Medal: Title: The Repair of Tissue Deficient Hernias by Aortic Implants
    Exhibitor: Samuel J. Fogelson and Roy G. Cooksey
  Bronze Medal: None
B. Educational Value
  Gold Medal: Title: The Conduction System in Cardiac Surgery
    Exhibitors: Maurice Lev, William L. Riker, Arthur De Boer, Thomas Baffes and W. J. Potts
  Silver Medal: Title: Effective Control of Toxemia
    Exhibitors: Herbert E. Schmitz, Michael P. MacLaverty and Robert S. Pavlic
  Bronze Medal: Title: Cholangiography—Operative and Postoperative
    Exhibitors: Karl A. Meyer, Peter A. Rose, Nicholas J. Capos and Joseph J. Litschgi
  Bronze Medal: Title: Hydatidiform Mole and Chorioepithelioma
    Exhibitors: Frederick H. Fall and Charlotte S. Holt
  Bronze Medal: Title: Leiomyoma Leiomyosarcoma of the Gastro-Intestinal Tract
    Exhibitors: Hildegarde Schorsch and HyHyun Byun

THE PRESIDENT: At this time I am going to call on Dr. Callahan to present a communication that he would like to read to the House.

DR. CALLAHAN: I have a letter addressed to me, which I should like to read, as follows:

"Dear Dr. Callahan:

Through you as Chairman of the Chicago Section of the United States Committee of The World Medical Association, I should like to extend to your state association the greetings and best wishes of The World Medical Association and its United States Committee for a most successful and profitable meeting.

The World Medical Association needs the support of every American physician in its struggle to maintain high standards in medicine and to protect the freedom of medical practice, both of which are threatened all over the world.

Sincerely yours,
Louis H. Bauer, M.D.
Secretary-Treasurer"

To that is also appended an invitation to attend the 14th General Assembly which we note is being held in West Berlin, Germany on September 15-22, 1960.

THE PRESIDENT: This requires no action by the House.

Dr. Cannady has an emergency resolution which he would like to present and which can probably be approved without reference.

DR CANNADY: WHEREAS: There are pending in the National Congress many and varied proposals for health care of the aged, including the Forand Bill, the Jeb Formula, the Administration proposal and the McNamara Retired Medical Insurance Act, and

WHEREAS: All of these proposals present revolutionary changes, are tremendously expensive, extremely complicated and poorly understood by and especially the respective beneficiaries, and

WHEREAS: Of all the proposals, only the Forand Bill has had a public hearing wherein Congress has provided by legislation a means for factual study of all problems of the aged through the mechanism of the White House Conference on Problems of Aging and Aged, to be held in January, 1961, now

THEREFORE BE IT RESOLVED: That the Illinois State Medical Society petition the Congress to defer legislative action on the proposals for health care of the aged until a thorough investigation and proper consideration of all facts have been completed, and

BE IT FURTHER RESOLVED: That a copy of this resolution be forwarded to the Honorable Everitt Dirkson and the Honorable Paul Douglas, members of the Senate; to each of the Illinois Congressmen and to each member of the House Ways and Means Committee.

I would like to add the suggestion that if this is adopted that it be immediately telegraphed to Congressman Mills, Chairman of the House Ways and Means Committee, and to the two Congressmen from Illinois on the committee.

I move that this resolution be adopted without reference. (Adopted)

THE PRESIDENT: Dr. Breed has a statement that he would like to make to the House.

DR. BREED: This matter is really a problem for the Chicago Medical Society but as we are all friends and as it may in some way affect or be of interest to you, we would like to present it to you.

At the May meeting of the Chicago Medical Society, Council permission was granted the Chairman of the Committee on New Home for the Chicago Medical Society to bring before the Illinois State Medical Society House of Delegates a brief summary of our plans as they may possibly concern the Illinois State Medical Society.

Let me state at the onset that the New Home is not a refuge for aged physicians, but is an office building for the Society. It is logical that a medical society of 6500 members should have its own up-to-date building, particularly when that society is located in a large city containing five medical schools, the main office of the A.M.A. and the national offices of many satellite societies.

This project has been the dream of the Chicago Medical Society for many years. About a decade ago, plans were made, land was secured from the West Side Medical Center and cleared for us but the plan was finally abandoned and the land turned back to the commission.

Medical societies must assume a greater role in civic affairs, in legislation, in politics and in shaping the coming changes in medical distribution. To fail to take our place at the planning table would permit strong groups with special interests to sacrifice the good of the masses for their own ends to say nothing of reducing the medical profession to the status of menial employees of the state.

The Illinois State Medical Society, in the past year, has made tremendous advance preparing to assume these responsibilities at the state level. They have employed trained personnel in key areas and have obtained a new large office. These costs are expensive and are destined to increase.

Looking forward, we must plan for the distant as well as the immediate future. It is easy to see great increase in activity and expense for the Chicago Medical Society. The possible magnitude of this increased cost is disturbing when one realizes that the Illinois State Medical Society increase this year over last will be in the neighborhood of $200,000. It is believed considerable savings will be made if we obtain our own building which we may operate tax free. This would enable us to escape the corporate tax, as well as real estate tax, interests and profits which we must pay when renting space in a loop building.

We are considering either building or taking over a building in the mile square West Side Medical Center. In the Center are three medical schools, Cook County Hospital, Presbyterian-St. Luke's Hospital, the University of Illinois Research Hospital and other smaller hospitals and medical buildings. This area is destined to be one of the greatest medical centers in the world.

The lot offered to us is 150′ by 291′ and lies between Harrison Street and Congress Expressway on the west side of Ashland Boulevard. The Congress Expressway is connected to a system of expressways that fan out over the entire city, of which are still under construction. It is easier to reach this site by car than to drive into the loop. The space is five minutes from the loop by cab or subway. The square mile east of the Medical Center, bounded by Ashland Boulevard and Halsted Street and by Roosevelt Road and Congress Expressway, is to be razed and high-rise apartment buildings are to be built. Across Ashland Boulevard from the proposed lot a large, modern motel is to be built.

On the north half of the proposed lot facing the expressway is a three-story, reinforced concrete building containing in all 42,000 square feet. This building could easily be made over into an attractive professional building. Possibilities for division of the space include offices for the Chicago Medical Society, 7500 square feet; meeting hall, 7500 square feet; library, 7500 square feet; a common mailing room of about 1,000 square feet; and a kitchen, small dining room, halls, washrooms and space for other medical groups. We are hopeful that we might also obtain the medical part of the John Crerar Library for the library space.

To fulfill this plan requires several steps.

First, the lot must be condemned and then the state legislature must vote money to purchase the lot and buildings; then the old buildings on the south end of the lot must be torn down and finally the property turned over to us. After this we must then make all alterations.

The name of the building perhaps would be "The Medical Societies Building".

We would anticipate that many of the satellite societies would be interested. In fact, I have talked to a number of them and I know they would be interested in taking space from us, particularly since the rent would be one-half of what they pay in the Loop.

Now, we hesitate to take over a building of 42,000

square feet unless there is some possibility that the Illinois State Medical Society may consider taking space from us. We believe a great deal of money could be saved by the ISMS if it did this, as the rent could be cut in half and much could be saved in the mailing room. The motel across the street would provide convenient housing for those who come from out of town.

If you believe that this plan should be given further consideration by the ISMS, I would suggest that a committee be appointed to meet with our CMS New Home Committee to investigate the possibilities and be instructed to make a report to the ISMS Council.

DR. HARRY MANTZ: I would like to speak in favor of the suggestion that Dr. Breed has made. It seems to me to be only good sense. We have decided to have our office here in Chicago, to make a type of plan for a permanent home. This is going to involve many years of thinking and planning on our part.

I certainly, as a downstate man, feel that we can live in the same building with the Chicago Medical Society without any difficulty at all.

I think that the planning should start now and therefore move that the President of the Illinois State Medical Society appoint a committee some time in the near future to consider this proposal. (Seconded)

DR. WHITE: I just want to inform you that this is not at all a new idea. I was a member of the Ad Hoc committee that was to choose a location after Chicago had been selected as the place to have our headquarters. Dr. Lull and Dr. Sweeney were also involved.

We made several trips and spent several days looking for a location. I inspected the location which has been described. I think it would cost a lot of money. Of course, when you talk about saving money, I really wonder how much you would save because you do have such things as upkeep and taxes.

As a downstate man I would like to say that never was I treated any better by an society than I have been by Chicago Medical Society and I have some of my best friends in Chicago. In spite of that, I vetoed the idea of having the Chicago Medical Society as a part of the building or part of the State Society. The reason for that was that there is no more reason, as I see it, why we should come up here and closely associate ourselves with Chicago, than you should come to Kewaunee and associate yourselves with Henry County. It was for that reason that I thought we should be separate.

However, I was only one. Fortunately, the committee concurred in the idea that we should be separate.

I do not see that we would save the money that has been suggested when you consider the money you have to raise to build the building and then to maintain it later.

I like the idea in a way—I surely do—and I have no quarrel with Dr. Breed or his proposal. However, I do not believe that this is what we are presently ready to do. I personally believe that we are pretty well located where we are.

I want you to know that this location, along with possibly some thirty-five others, were considered. We did not take the most expensive location nor did we take the cheapest and there wasn't much difference between the cheapest and the one we got, which we think is an excellent location.

I give you this as a matter of information and also that you may use it in connection with your judgment as to what to decide to do.

THE PRESIDENT: Dr. Breed, it is the position of the chair that we should not take too much time from the business of the House to discuss something which is so far distant.

DR. BREED: Of course, we have to think of the future because anything of this sort has to be projected for fifty years, I would say.

I would also like to thank Dr. White for his statements. I am not trying to sell this to you at all. However, to my way of thinking it is a very significant thing and all that we are asking is that we get some sort of idea as to what we are to do. We have the committee and we have to come up with some answers in Chicago. We cannot come up with some of them unless we know your feeling.

I might add that the building would be completely built and financed by the Chicago Medical Society and it is not going to be too difficult to take the building over. This is a building of some 42,000 square feet and we can take it over without help from the state society. It is just a matter of whether or not it would be advisable for us to be together.

I did not even move that a committee be appointed by this body. What I asked for at this time was just a directive from you and then someone else made that motion. Of course, we will be happy to sit down with your committee and we may decide that the ideas of Dr. White will prevail. However, we simply want to know where we stand. We are not trying to sell you a thing.

DR. G. H. MUNDT: I should like to speak on this because I think that it is a very great problem.

In the first place, 25 or 30 years ago, the Chicago Medical Society took on a building and we lost it. I happened to have been President of the Illinois State Medical Society at that time and I put in quite a little bit of money. Of course, I am not trying to bring out the fact that I am worried over the loss of the money but, rather, that we have tried this thing.

I have said to numerous people that they should look at the building the New York State Medical Society erected and then decide whether they want us to do that thing. Neighborhoods change, and there are many other things that change.

What I would like to stress is that you should take warning and see what has happened in other organizations and I think that you will then be able to see what we should do. Please consider this matter very carefully. I have a very high regard for Dr. Breed and I have every confidence in him. However, think three times before you move once.

THE PRESIDENT: The motion before the House is that the President of the Illinois State Medical Society appoint a committee to look into this matter. (Carried)

THE PRESIDENT: We shall now return to the Reference Committee reports which were considered at the second meeting of the House of Delegates.

Reference Committee on Reports of Council Committees, No. 1.

Dr. Julius M. Kowalski, Chairman.

Your Reference Committee on Reports of Council Committees met in executive session following the open hearings held Tuesday, May 24, 1960, in Room 108, Sherman Hotel, Chicago, Illinois and reports to you as follows on the work of these advisory committees for the year 1959-1960:

(1) The Committee reviewed the report of the Dependent Medical Care Program Committee and wishes to comment as follows:

There was considerable discussion by Committee members and from interested persons in the gallery. Points of interest are as follows:

(a) Attention should again be called to the fact that the Medicare program for dependents of uniformed personnel was curtailed on October 1, 1958. It will be recalled that the Council of the Illinois State Medical Society renewed its contract under protest, due to certain restrictions. The program has now been revised and most of these restrictions rescinded as of January 1, 1960. More emphasis should be placed on the fact that the dependent medical care program is a $15.00 deductible plan and the recipients should be informed as to this facet of the plan.

(b) Dr. Percy E. Hopkins emphasized the fact that no definite fee schedule is set up for this plan, other than the usual fee in the community. In cases of unusual fees, the physician concerned may take this up with the Committee at the state level, and Dr. Hopkins further states that in every case where such a fee has been justified, it has been allowed.

(c) Dr. Hopkins further brought out the fact that these fees are considered and recommendations are made by members of the medical profession and not by lay persons.

This Committee approves the annual report of the Advisory Committee on Dependent Medical Care Program. I move the adoption of this portion of the report. (Adopted)

2. The Committee reviewed the report of the Illinois Public Aid Commission and wishes to comment as follows:

This committee is to be commended for its efforts to see that good medical care is available to recipients of public aid and that physicians' fees were increased slightly this year, in spite of the veto of annexed legislation designed to provide such increase. Fees for office calls were raised to $3.00 from $2.00, house calls are now $4.50 and night calls $6.00. The committee heard testimony from Drs. J. W. Compton and Fr. Lehr that physicians' fees are still too low, particularly in such categories as obstetrical care and anesthesiology. Dr. E. A. Holmblad, the Medical Director of the Illinois Public Aid Commission, explained that negotiations have been under way for nine months in this regard. He also stressed that his office preferred to issue as few directives as possible, avoiding a dictatorial attitude, and encouraged the handling of medical and administrative problems at the local or county level as much as possible. Such local committees can explain the allowed or customary charges and procedures to their colleagues.

The Reference Committee was impressed with the Advisory Committee's report and its work, and with Dr. Holmblad in his sympathetic and interested understanding of the entire problem, including the interest of the public and the physicians.

This Committee approves the annual report of the Illinois Public Aid Commission. I move the adoption of this portion of the report. (Adopted)

4. The committee reviewed the sub-committee report of the American Legion (Illinois Division) and wishes to comment as follows:

The report disclosed that the committee found no need for a meeting last year and your Reference Committee recommends the acceptance of this report. (Accepted)

5. The committee reviewed the report of the sub-committee on Civil Defense and wishes to comment as follows:

Pamphlets were prepared and distributed by the Federal Civil Defense Administration and were helpful to state committees and physicians working with directors of civil defense in various counties, in explaining policies and participation in preparations.

Several members of the committee attended the Sixth Regional Meeting of the A.M.A. Committee on Disaster Medical Care in Chicago and the 10th Congress of the County Medical Societies' Civil Defense. Rural communities removed from target areas will certainly be involved in these problems in the event of a thermal nuclear war.

The State Department of Public Health is definitely established as important in civil defense and disaster planning in relation to other agencies. In its Bureau of Hospitals, the State Department of Health has an Illinois State Plan for the Pre-positioning of Civil Defense Emergency Hospitals. Fourteen are already in existence and 102 are on the program list.

A summary of requirements of food and drink sufficient for a family of five for a two weeks' stay in a bomb shelter has been prepared by a member of this committee. Copies have been widely circulated.

A small but well disciplined and informed group of Illinois doctors called "The Flying Physicians" can be activated quickly for help in civil defense.

Although activities in the various county and branch societies of the state are improved over those of a year ago, continued development is necessary. A strong, well trained, national civil defense is an active deterrent against thermal nuclear blackmail.

The committee approves the report of the Sub-committee on Civil Defense. I move the adoption of this portion of the report. (Adopted)

6. The committee reviewed the report of the Coroner's Committee and wishes to comment as follows:

It is the opinion of your Reference Committee that the Coroner's Committee, under the able chairmanship of Dr. Edwin E. Hirsch, has done an important and excellent job in the part it has played to improve the quality of work of this all-important office. The Illinois State Medical Society can look with pride upon the excellent progress that has been made, in spite of recent apparent set backs. This committee deserves our congratulations.

This committee approves the annual report of the Coroner's Committee. I move the adoption of this portion of the report. (Adopted)

7. The committee reviewed the report of the Sub-committee on Selective Service and wishes to comment as follows:

This report was read with interest and cognizance was taken of the death of a valuable and dedicated member of the committee for many years, Dr. Roland R. Cross, Illinois Director of Public Health, whose tempered judgment, wise counsel and ever helping hand will be sorrowfully missed.

This committee approves the report of the Sub-Committee on Selective Service. I move the adoption of this portion of the report. (Adopted)

8. The Committee reviewed the report of the Sub-Committee on Veterans Administration. We wish to comment as follows:

Emphasis was placed by the committee on continued adequate care for all service-connected disabilities and for all cases involving financial need whether service-connected or not.

In certain situations wherein it would impose a hardship on a veteran to travel to a distant veterans facility for care, that individual, we feel, should have the right to choose care from a private physician in a private facility at federal expense.

At the committee hearings it was brought to our attention that at times a doctor was confronted with the situation wherein he, in attempting to hospitalize a veteran, was refused admittance by a veterans hospital, only to have that patient admitted to the same facility following a phone call from a lobbying group, such as a veterans organization.

Realizing full well that pressure groups will always be interfering with the orderly management of medical problems best understood only by the medical profession, we wish to express our disapproval of such actions and feel that this should be brought to the attention of the sub-committee on Veterans Administration.

This committee approves the report of the Sub-committee on Veterans Administration. I move the adoption of this portion of the report. (Adopted)

9. The committee reviewed the report of the Advisory Committee to the Woman's Auxiliary and wishes to comment as follows:

The state officers of the Woman's Auxiliary and those of the component county auxiliaries have been untiring in their efforts to continue the development of an enthusiastic and financially self-sustaining organization. It now numbers 2,700 women who in the past year have been most active in the fields of state and federal medical legislation, community services, civil defense, and the American Medical Education Fund. A favorable liaison has existed between the Advisory Committee and these exemplary women. It is the wish of this committee that a vote of confidence be given to the Woman's Auxiliary for their many accomplishments.

This committee approves the report of the Advisory Committee to the Woman's Auxiliary. I move the adoption of this portion of the report. (Adopted)

10. The Committee reviewed the report of the President of the Woman's Auxiliary and wishes to comment as follows:

Under the dynamic leadership of Mrs. John van Prohaska, the Woman's Auxiliary has tried new meth-

ods in meeting the ever-changing problems in medical legislation, nurse recruitment, community services, civil defense and other endeavors. In bringing the program to county level participation, new techniques were used in the form of round tables, talk and program clinics in various districts throughout the state. This resulted in greater participation by many more members than heretofore. There are now forty-one auxiliaries in forty-seven of the ninety-one counties which have county medical societies. The theme this year was "Accept Individual Responsibility for Better Community Health."

The President and her staff of state officers attended many conferences in and out of the state on medical care for the aged and federal legislation. They have earned the cooperation of individual members and made their numbers felt, particularly in writing letters to legislators where their husband-physicians often would not.

For the many spectacular achievements, this reference committee recommends a vote of confidence and appreciation to Mrs. John van Prohaska, President of the Woman's Auxiliary. (Voted)

This committee approves the report of the President of the Woman's Auxiliary. I move the adoption of this portion of the report. (Adopted)

DR. NORBERG: I would like to go back to number eight for a moment and make a comment if I may.

I read the report and there are some very excellent statements made and one is, of course, the non-service-connected disabilities.

As you know, a veteran with a hernia or some such disability can have the hernia repaired at government expense and then he may apply for a non-service-connected disability and receive a pension for the scar that was made for the hernia.

Now, whether or not this particular thing has taken place I do not know but there have been, I am sure, times when veterans applied for non-service-connected disabilities for such situations as I mentioned and have received them, so that they can get free medical care and then get a pension on top of it.

It appears to me that we ought to be much more active in studying this question of non-service-connected disability in the veterans hospitals in view of the fact that the government is building more and more hospitals for the care of the veterans and not for service-connected disabilities.

I spent four years in the wards of one of these veterans institutions and I did not know at the time I went there for my residency just how this worked but then being there for some few years I saw this happen. The veteran is admitted after he signs a statement to the effect that he cannot pay for care in a private hospital. He is not told what he is signing but is just told that he has to put his name on this paper. However, in many cases the patient can pay. In fact, I repaired the hernia on a very important man in this city who has a business and, I am sure, is not a pauper.

I have seen a mother wearing a mink coat and diamonds on all of her fingers coming to the hospital to visit a son who had signed a pauper's oath.

As I understand it, the statement that the veteran signs cannot be used against him in any way so that the government cannot collect for any of the services that this veteran received free of charge.

As I say, the government is building more and more hospitals. Does this mean that a service-connected disability gets worse—does the service-connected disability need more and more care in the future or are they building these hospitals for the care of the non-service-connected disabilities that are going to take place?

As I recall, in some of these wards we had more World War I veterans who were having their prostates fixed, hernias repaired and other such things than we had service-connected disabilities from World War II. In fact, some of the service-connected disabilities had to sort of take a back seat while the non-service-connected disabilities were being taken care of.

This is a problem that we should really study. This is something that we should have a real active committee on. If we are going to be socialized, then this is one of the back doors to socialized medicine.

DR. KOWALSKI: Your reference committee considered resolution No. 17 as introduced by the Sangamon County Medical Society, subject: "Oral Prescriptions for IPAC Recipients".

We wish to state that the following changes would be applicable:

In paragraph 5, following the words, "orders to pharmacists", add "of the patient's choice." and

In the last paragraph, after the words, "Ordering by physicians of prescriptions" add "to pharmacists of the Illinois Public Aid recipients' choice, with the further provision that the physician mail or otherwise transmit with reasonable promptness to the pharmacist a written prescription to cover the original verbal order and all refills he authorizes."

This committee approves resolution No. 17 with the changes as read. I move the adoption of this portion of the report. (Seconded)

DR. MONTGOMERY: I was unable to appear before this committee at the time that this was considered and I hope that the committee had a full understanding as to the requirements of the Illinois Public Aid Commission in fulfilling the necessity for prescription signed by physicians with the recipient when he obtains drugs.

I believe the difficulty here arose due to the fact that on a few occasions we have had drug stores which piled up oral prescriptions and then when they were checked nobody would vouch for the fact that they wrote these prescriptions. There was no method of check. The patient did not know whether he got the drugs and actually the Drug Committee and the Drug Association of the state filed suit against some of these drug stores because of that very thing.

At that time it became necessary to try to adopt some planning under which the control of prescribed drugs could be covered and that plan was to adopt the prescription that is now used, which has to be signed by both the doctor and the patient.

That was purely and simply a method to try to conserve funds because the Public Aid Commission had to go before the legislature this year and request a $35 million deficit budget.

The cost of drugs far exceeds the amount of money paid to doctors in the State of Illinois and when you realize it, the tremendous implication that is involved in oral prescriptions is something that therefore would be considered very seriously.

THE PRESIDENT: Are there further comments. Hearing none, I will put the motion to adopt this portion of the report. (Adopted)

DR. KOWALSKI: Your reference committee wishes to thank the society members who appeared before it to share their experiences and unique problems. Though some discussions were brisk, they were, nontheless, enlightening. This is indicative of a healthy, adaptive membership.

As your chairman, I am grateful indeed to have had the whole-hearted support and considered counsel in these deliberations from the committee members. My sincere thank you goes to them.

I move for the adoption of the report as a whole. (Adopted)

THE PRESIDENT: Thank you, Dr. Kowalski, for a job well done. I believe that you also have a supplementary report?

DR. KOWALSKI: This is a supplementary report on Resolution #35, subject: "Prohibiting Price Advertising by Optometrists And/Or Opticians in the State of Illinois".

Your reference committee met in executive session

on May 25, 1960, with the sponsor of this resolution and other interested parties and we wish to comment as follows:

Your committee feels that the Illinois State Medical Society should not enter into any price controversy involving ancillary and/or quasi medical organizations. The committee recommends that such problems can best be resolved by component county societies at local level if the need arise.

I move the adoption of this supplementary report and action on resolution No. 35. (Adopted)

THE PRESIDENT: Before calling on the next reference committee, I wish to present a report from the Committee on Credentials:

"This is to certify that at the first meeting of the House of Delegates on May 23, 1960, sixty-two counties were represented with 184 delegates. We move that this constitute the voting strength of this house."

It further states as follows:

"This is to certify that at the second meeting of the House of Delegates on May 25, 1960, sixty counties were represented and 173 delegates. We move that this constitute the voting strength of this house."

Then we have one more statement:

"This is to certify that at the third meeting of the House of Delegates, on May 26, 1960, fifty-five counties were represented and 156 delegates. We move that this constitute the voting strength of this house."

In commenting upon this may I say that there are ninety-two component medical societies in the state association. Need I say more?

All those in favor of the report of the Credentials Committee say "aye"; those oppposed "no". It is so ordered and the report of the Credentials Committee is accepted.

Reference Committee on Reports of Council Committees, No. 2.

Dr. Edwin F. Hirsch, Chairman.

This reference committee received committee reports as follows:

1. Committee on Aging: The report as given by the Committee Chairman, Dr. Edward W. Cannady, details a positive investigation of one of the most pressing and complex social and economic problems confronting medicine today. This committee has held meetings and has engaged in many other activities in seeking to formulate a program for the health needs of our senior citizens. Your reference committee commends the progress and the contemplated program of action which this Committee on Aging has initiated.

I move the adoption of this portion of the report. (Adopted)

2. Liaison Committee to the Illinois Bar Association: I move the adoption of this portion of the report. (Adopted)

3. Committee on Birth Certificates: I move the adoption of this portion of the report. (Adopted)

4. Committee on Disease Control: Dr. J. W. Majarakis reported that this group had satisfactory work arrangements. Then followed reports of the subcommittees, by Dr. Caesar Portes on Cancer Control, by Dr. Arnold S. Moe on Cardiovascular Disease, by Dr. F. G. Norbury on Mental Health, and by Dr. E. A. Piszczek on Tuberculosis Control. An inequality in fund distribution because of the law providing an appropriation for cancer control was emphasized.

A supplementary report by the Committee on Tuberculosis will appear in the published report.

I move the adoption of this portion of the report. (Adopted)

Your reference committee received for hearing seven resolutions from the Will-Grundy County Medical Society, one from the Effingham County Medical Society and three from the Kendall County Medical Society. A lively discussion took place during and after the presentation of these resolutions. All of these resolutions propose directives or pronouncements to or actions by the House of Delegates on insurance plans, health services, fee schedules and other professional relationships for persons of our communities who are sixty-five years of age or older. They also express some dissatisfaction with certain procedures or arrangements that have been publicized by mail, through the press, or other mediums.

Your reference committee realizes that communications between individuals and especially between groups through authorized representatives suffer when time is limited for these purposes. The committee emphasizes that actions taken under these circumstances by our representatives, the Councilors, are with the best of intentions for the good of all in our medical society as well as for the patients.

Your reference committee therefore recommends that the House of Delegates request the Council of the Medical Society to refer the substance of these resolutions to a committee for full review, analysis and recommendation to the Council for appropriate decisions.

I move the adoption of this portion of the report. (Seconded)

DR. SAXON: I attended this particular reference committee meeting on a late schedule, having tried to appear in three different reference committees in connection with the multitude of resolution that were offered for consideration and am sorry that I missed out on some of the conversation that went on. However, I would like to emphasize a few points that I think are of significance.

First of all, I would like to say that I am certain beyond any question of doubt that we are in opposition to socialism.

The method and the manner in which we attack this problem meets some diversity of opinion. Also, the question of need and urgency of need also merits some consideration.

I would like to refresh the memory of those of you delegates who attended the December meeting, at which we combined all nine of our resolutions. It was felt at that time that the resolution was a rather deeply involved one with many facets.

We cannot expect medical men to understand the essence of what constitutes socialism. I feel that this is a matter for study, not only by the House of Delegates. but by the Council as well.

Now, in connection with the method in which this is attacked. If we assume that we have a knowledge of what constitutes socialism, then we have certain dividing line opinions—we are either for things that represent freedom or we are partly social in our thinking and would thus feel that we could support things that are partly social as an expedient to meet a realistic need that someone has quoted; or we can go overboard and go completely socialistic in connection with our thinking. I am sure that this is what most of us do not want.

The main purpose of our resolution in December was to have the membership consider our Blue Shield Plan for aging, with a fixed fee label attached to it, another form of socialism. We would have hoped that perhaps medicine would have taken into consideration the thought for the best interest and welfare of the people and that socialism as it affects us would probably be brought forth in another resolution from another committee. However, unfortunately this matter has now been divided and so I have to speak in connection with all of these resolutions in order to defend our position.

I regret very much that the insight and the division of thinking did not include a certain amount of freedom that would otherwise be present. As has often been said, it is very difficult for a woman to be just a little bit pregnant and, in that connection, I don't think that we can have a little bit of socialism and that we should not even sponsor a little bit at any level.

I would feel that in this particular gathering we

should reconsider these resolutions to the extent that socialism does have an influence on mental and physical health. The mental and physical health portions of this particular kind of thinking I have put together in a report so that I will not be mimicking myself too much and I will, therefore, try to hit this thing as I see it.

In the passage of time, those of us who are called upon to care for the medical needs of the people of our communities are faced with increase in mental and physical complaints of people we serve.

I am sure that you will all agree, especially in connection with reading the newspapers, that one in seven people now take tranquilizers or sedative medication and the last time that I gathered statistics it was one in ten. I wonder how many of us require that kind of medication.

It is not merely by chance that this has taken place. In the practice of medicine in its more formative manner and to the best advantage of our patients, we always attempt to follow a certain pattern of investigation. First we elicit the patient's symptoms and a history of the illness and its distinguishing characteristics. Then we probe further to determine the cause and then use x-ray and other laboratory procedures to aid in this. All of these expensive diagnostic procedures distinguish functional disorders from organic disease and in order to make it possible to make the decision and distinction, they become almost indistinguishable at times and thus we have the problem of assuring the patient that he has no disorders whatsoever.

In so doing, the physician must also assure himself that no organic disease is present. Approximately ninety per cent of the x-rays taken at the local hospital in Aurora reveal no disease. Other laboratory procedures, I am sure, fall into a similar percentage category of disease.

It has been shown statistically that one in seven people now take tranquilizers or some medication of this sort.

What does all of this mean? It means that many of the illnesses for which people seek treatment by the physician are due to emotional or nervous disturbances. From experience, I would say that there is a gradual increase in these complaints.

THE PRESIDENT: Dr. Saxon, do you think that you are straying far afield from the purpose of the motion, which was to refer this to the Council for consideration?

DR. SAXON: This is a matter of discussion of the resolutions.

THE PRESIDENT: The chair wants to give the greatest latitude in these matters but it is the opinion of the chair that you are not discussing the motion.

DR. SAXON: These are items that certainly lead up to the results in connection with the resolutions.

THE PRESIDENT: Go ahead but it is very difficult for the chair to feel that you are discussing the motion.

DR. SAXON: I shall say only one item in conclusion and in order to respect the opinion of the chair, and that is that we feel that nervous or mental disease are certainly produced directly and indirectly by socialism and its effects on the social economics of people. These are the things that indirectly produce the symptoms for which we see patients. Therefore, we feel that we should take an active stand and use this as a weapon to oppose things that are socialistic.

DR. WILLIAM HART: We introduced several resolutions relative to this problem and they were separated. The point that I wish to make is that these are antagonistic, these are complaining and we in Peoria County do not wish to make the payment in full basis. We complain and object and that is the basis for our resolutions and the purpose for their introduction.

We hope that they will not be snowed under in committee and, in effect, be lost.

DR. L. F. ROBLEE: I am probably going to reiterate a great deal of what the delegates from Peoria County said. However, I do want to emphasize one point and that is that in our own society we not only objected to the idea of a fixed fee but we felt that in spite of the urgency of the situation that there were errors made and that the whole situation was not properly given to our society and our members.

It was an error that perhaps was justified but the members of our society feel strongly that it was an error to the public, to our patients and they were informed regarding things which we were not aware of at the time and, therefore, that was one of the big things that we were trying to express for our society.

DR. MILLIGAN: I think that the Kane County delegates are willing to accept the portion of the report in which it is stated that the Councillors acted with best intentions and for the good of all. However, it is our feeling, and I think that it has come out in the various discussions of this subject, that the Council had sold itself on the notion that to socialize ourselves, to present a proposition in which we socialize ourselves and renounce certain of our own ideals was the only method by which we could combat socialized medicine in various bills that were being currently proposed.

I think that it has come out in all of the discussions that it probably was not the intent of the Council to allow the body of the medical society to vote upon the principles involved, namely the principle of accepting fixed fees.

You know, when we started out in medical practice we all agreed and vowed that we would take care of the ill regardless of their economic status. This proposal made by the Council relieves us of this responsibility.

Without being too wordy, I would also like to recall to your mind that without responsibility there cannot be morality and, of course, we do have to uphold the high moral traditions of our profession.

I do not expect this to be too clear because it was said too briefly. However, the society was not allowed in the poll to vote upon the principles. The House of Delegates did not authorize the Council to make public a plan such as it did. I think that this is clear.

We eventually saw the results of what happpened. We have committed ourselves as a society to feeding these government people with a bit of our freedom and with a bit of our moral responsibilities. This, I believe, is wrong.

We saw what happened when the Forand Bill was considered by the House Ways and Means Committee. I think it is still mistakenly supposed by certain members of the Council that our giving away of a portion of our freedoms changed the minds of the House Ways and Means Committee. Of course, nothing could be more unrealistic. The only thing that convinced them to change their minds and hold the bill back was the show of political strength by our organization. I think that this is something which is little realized by the medical profession—that we hold probably a better political organization than either of the major parties. Consider for a moment that we are a body of two hundred thousand people and we are in a position, and especially a good position, to influence at least another 200,000 votes. Actually, I would say that we see a million voters a day. Therefore, we are not small and do not have to fear the politicians.

I also think that this was well illustrated in our letter writing campaign to the House Ways and Means Committee and to the various members of Congress. I emphasize that it was not our giving up our freedoms that did anything—that is was just merely this political element that showed the Congressmen that we had much more strength ourselves, combined with the Chamber of Commerce, the Farm Bureau and a few others of lesser importance to overcome the great strength of these others.

DR. BELL: We have heard some of these speeches so many times that we already know them by heart. I

am sure that we agree in principle, and I would like to remind you of some facts.

First of all, all of the over sixty-five policies offered in this state are indemnity plans—they do have certain service features but they are indemnity plans.

Secondly, I do not believe in the philosophy that we are all out of step but Jim, and Jim should get everyone else in step. The vast majority of our Blue Shield plans are built along these lines—a service plan and an indemnity plan with a service feature.

We have also enrolled in this state almost fourteen thousand over sixty-five citizens.

I would like to call your attention to the fact that the system of divide and conquer has been the basis that has destroyed civilizations through the centuries. It has destroyed the English medical profession and it is going to destroy the liberties of the Canadian medical profession. In fact, it has already done so for hospitals.

I ask, are we going to divide ourselves and be destroyed or are we going to get together on one solid front?

For once I would like to call for the question.

DR. KOWALSKI: I would simply like to call your attention to the concluding paragraph of the report, which is the matter on which we are going to vote. I should like to read it again.

(The concluding paragraph was then again read.)

THE PRESIDENT: That is the substance of the motion. Are you ready for the question?

DR. B. A. SAMP: I agree with what the reference committee has proposed here, of sending this to committee. However, I would like to propose again what I proposed in the committee that considered the resolution—three questions which, for the consideration of the committee, they might formulate—and they are these:

1. Does the Illinois State Medical Society have any right or power to legislate fixed fees for membership of the society? If the society does have such a right, then will it entertain to provide medical care to certain other groups that need medical care? For instance the group might include people in a very low employment status or special organizational groups that want fixed fee insurance policies and student groups.

2. If the fixed fees are legislated by the society, how binding are they on the membership of the society as a whole? Does everyone have to go with those?

3. If everyone doesn't have to go with these, are we not then doing what we do not want to do—interfering with the right of the patient to choose his own physician?

In answer to that third question, if a patient came to a physician and said, "I am a participant in a fixed fee schedule," and the physician said, "I am sorry, Joe, but I don't participate in that myself," then I believe that this primary choice has been violated there and then he has to select a physician from a panel that participates in the fixed fee plans.

(The question on the motion was then called for.)

THE PRESIDENT: The question is to adopt this portion of the report and refer these resolutions to the Council—that a special committee be appointed within the Council to further study these resolutions. Do you all understand that?

(The motion was then voted upon and carried.)

DR. HIRSCH: I move the adoption of the report as rendered—of the report as a whole. (Adopted)

THE PRESIDENT: The next item on the agenda is the report of Council Committee No. 3.

Reference Committee on Constitution and Bylaws

Dr. William H. Schowengerdt, Chairman.

Your reference committee to receive and report on suggested changes in the Constitution and Bylaws met in executive session following the open hearing in the Orchid Room on Tuesday, May 24, 1960, at ten o'clock, and wishes to report to you as follows:

ARTICLE II—PURPOSES OF THE SOCIETY

Add the words, "to serve, and thereby strengthen component county societies," after the words "American Medical Association." Line 6.

So that Article II as amended will now read as follows:

"Article II—Purposes of the Society: The purpose of this society shall be to federate and bring into one compact organization the entire profession of the State of Illinois, and to unite with similar societies of other states to form the American Medical Association; to serve and thereby strengthen component county societies; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to study and improve the standards of medical care and to inform the public and the medical profession concerning the advantages of good medical care."

I move the adoption of this portion of the report. (Adopted)

ARTICLE V—HOUSE OF DELEGATES.

This article will become FOUR SECTIONS instead of three paragraphs.

"Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Council. The House of Delegates shall set the basic policy and philosophy of the Society."

"Section 2. The House of Delegates shall consist of: (a) delegates elected by the component societies; (b) the officers of the Society; (c) the past preisdents; (d) both general officers and members of the House of Delegates of the American Medical Association from the Illinois State Medical Society."

Paragraph 2 now becomes Section 3.

Paragraph 3 now becomes Section 4.

Article V, Sections 1, 2, 3, 4, as amended, will now read as follows:

ARTICLE V—HOUSE OF DELEGATES.

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Council. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall consist of: (a) delegates elected by the component societies; (b) the officers of the Society; (c) the past presidents; (d) both general officers and members of the House of Delegates of the American Medical Association from the Illinois State Medical Society.

Section 3. All recommendations of the House of Delegates dealing with the acquisition or disposal of property of any kind, or with the appropriation or expenditure of funds, must be approved by the Council.

Section 4. Fifty delegates representing not less than twenty counties shall constitute a quorum for the transaction of business."

I move the adoption of this portion of the report. (Adopted)

ARTICLE VI—THE COUNCIL

Section 1. Add in line 11 after the words "secretary-treasurer" a new sentence: "The Vice Presidents, the presiding officer and the alternate presiding officer shall attend the meetings, (including executive sessions) with the right of discussion but without the right to vote."

Add a new Section 2: "The Council shall employ an executive administrator whose duties shall be determined by the Council. He shall be responsible to the chairman of the Council. The Council shall also employ such other people as are needed for the conduct of the affairs of the Society."

Section 2 becomes Section 3.

Section 3 becomes Section 4.

Section 4 becomes Section 5.
Section 5 becomes Section 6.
Section 6 becomes Section 7.
Section 7 becomes Section 8.

Article VI, Sections 1 and 2 as amended will now read as follows:

"ARTICLE VI—THE COUNCIL.

Section 1. The Board of Trustees, or as in this Constitution and Bylaws designated, The Council, whose duties are executive and judicial, shall consist of sixteen councilors elected by the House of Delegates, (six shall be chosen from district number three and one from each of the other ten districts, these districts of the geographical area as of May, 1946), and one councilor-at-large (the retiring president, who shall serve a term of one year), the president, president-elect and secretary-treasurer. The vice presidents, the presiding officer and the alternate presiding officer shall attend the meetings, (including executive sessions) with the right of discussion, but without the right to vote. Besides its duties mentioned in the Bylaws, it shall have charge and control of all property belonging to this Society of whatsoever nature, and of all funds belonging to this Society from whatsoever source.

Section 2. The Council shall employ an executive administrator whose duties shall be determined by the Council. The shall be responsible to the chairman of the Council. The Council shall also employ such other people as are needed for the conduct of the affairs of the Society."

I move the adoption of this portion of the report. (Adopted)

Article IX—Officers.

Section 1. Add in the fourth line, after the words "secretary-treasurer," "a presiding officer and an alternate presiding officer of the House of Delegates."

Section 2. In line 2, after the words "secretary-treasurer" add "and beginning at the 1961 annual meeting, a presiding officer and an alternate presiding officer" shall be elected, etc.

In Section 2, add a new paragraph:

"The presiding officer and alternate presiding officer shall not be elected for more than three consecutive terms for their respective offices; they shall be elected from among the House of Delegates."

Therefore, Article IX, Sections 1 and 2, as amended, will now read as follows:

"ARTICLE IX—OFFICERS:

Section 1. The officers of this Society shall be a president, a president-elect, a first vice-president, a second vice-president, a secretary-treasurer, a presiding officer and an alternate presiding officer of the House of Delegates, sixteen councilors and one councilor-at-large.

Section 2. The president-elect, vice presidents and secretary-treasurer and beginning at the 1961 annual meeting, a presiding officer and an alternate presiding officer shall be elected annually by the House of Delegates to serve for a term of one year. The councilors shall be elected by the House of Delegates to serve for three years. All officers shall serve until their successors are elected and installed. The presiding officer and alternate presiding officer shall not be elected for more than three consecutive terms for their respective offices; they shall be elected from among the members of the House of Delegates."

I move the adoption of this portion of the report. (Adopted)

Chapter II—Annual Session of the Society:

Section 1. Delete the first paragraph and substitute "the Council shall determine the date for the Annual meeting."

The second paragraph then becomes Section 2.

Therefore, Chapter II, Sections 1 and 2, as amended, will now read as follows:

"CHAPTER II—ANNUAL SESSION OF THE SOCIETY:

Section 1. The Council shall determine the date for the annual meeting.

Section 2. The meeting place for the annual session shall be determined by the House of Delegates from a list of cities extending invitations, subject to investigation of the facilities and approval by the Council."

I move the adoption of this portion of the report. (Adopted)

Chapter III—General Meetings:

Section 1, Line 6—delete: "The address of the president and." This matter is covered in Chapter VII—Duties of Officers.

Chapter III, Section 1, as amended, will now read as follows:

"CHAPTER III—GENERAL MEETINGS:

Section 1. All registered members may attend and participate in the proceedings and discussions of the general meetings and the section meetings. The general meetings shall be presided over by the president or by one of the vice presidents. The oration on medicine and surgery shall be delivered at the general meetings."

I move the adoption of this portion of the report. (Adopted)

Chapter IV—Sections.

Add a new Section 6. "The officers of the sections shall arrange the program for the section in coordination with the Committee to Program the Annual Meeting."

I move the adoption of this portion of the report. (Adopted)

Chapter VII—Duties of Officers.

Section 1. Delete "and at the meetings of the House of Delegates" and substitute "or designate one of the vice presidents to substitute for him, should he be unable to be present".

Section 2 remains the same.

Section 3 remains the same.

Section 4 is changed to: "The presiding officer, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require. He shall announce the reference committees as appointed by the president, the president-elect of the Society and chairman of the Council."

Section 5. Delete and change to new section as follows:

"Section 5. The alternate presiding officer shall officiate for the presiding officer in the latter's absence, or at his request. In case of death, resignation or inability of the presiding officer to perform his duties, the alternate presiding officer shall officiate during the unexpired term."

Add a new Section 6.

"Section 6. Secretary-Treasurer. In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage and those granted or imposed in other provisions of the constitution and these bylaws, the secretary-treasurer shall: (a) be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Council. The Council may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom. The secretary-treasurer shall give bond in such sum as may be fixed by the Council, the premium on such bond to be paid for by the Society; (b) perform such other duties as may be directed by the House of Delegates or by the Council."

Chapter VII, Sections 1, 4, 5 and 6, as amended, will now read as follows:

"CHAPTER VII—DUTIES OF OFFICERS:

Section 1. The president shall preside at the general

meetings of the Society, or designate one of the vice-presidents to substitute for him, should he be unable to be present. He shall appoint all committees not otherwise provided for; shall deliver an annual address at such time as may be arranged and shall perform such other duties as custom and parliamentary usage may require.

Section 4. The presiding officer, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require. He shall announce the reference committees as appointed by the president, the president-elect of the Society and chairman of th Council.

Section 5. The alternate presiding officer shall officiate for the presiding officer in the latter's absence or at his request. In case of death, resignation or inability of the presiding officer to perform his duties, the alternate presiding officer shall official during the unexpired term.

Section 6. Secretary-Treasurer. In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage and those granted or imposed in other provisions of the constitution and these by laws, the secretary-treasurer shall: (a) be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Council. The Council may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom. The secretary-treasurer shall give bond in such sum as may be fixed by the Council, the premium on such bond to be paid for by the Society; (b) perform such other duties as may be directed by the House of Delegates or by the Council."

I move the adoption of this portion of the report. (Adopted)

Chapter VIII—The Council: Section 1. Delete the second paragraph: "The Secretary of the Society shall be secretary of the Council."

Chapter VIII, Section 1, as amended, will now read as follows:

"CHAPTER VIII—THE COUNCIL:

Section 1. The Council shall meet daily during the annual session of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the councilors. It shall meet on the last day of the annual session of the Society to elect a chairman who shall make an annual report to the House of Delegates."

I move the adoption of this portion of the report. (Adopted)

Chapter IX—Committees:

Section 1. Delete "and Public Relations" from line four to read: "A Committee on Medical Service."

Delete "A Committee on Scientific Work" and substitute "A Committee to Program the Annual Meeting."

Add a new committee, "A Committee on Public Relations," and change the order of the committees to read:

A Committee to Program the Annual Meeting.
A Committee on Medical Service.
A Medico-legal Committee.
A Committee on Medical Education and Hospitals.
A Committee on Medical Testimony.
A Committee on Medical Benevolence.
A Grievance Committee.
A Committee on Prepayment Plans and Organizations.
A Committee on Public Relations.

Delete Section 2 entirely and substitute a new section:

"Section 2. The Committee to Program the Annual Meeting shall consist of at least nine members, one-third to be appointed annually by the Council to serve a term of three years, except that when first constituted, three members shall be appointed for terms of three years, three for terms of two years and three for terms of one year.

It shall be the duty of this Committee to coordinate the programs for the General Assemblies, the section meetings and the scientific exhibits at the annual meeting. It shall recommend to the Council a secret committee to make the awards to the scientific exhibitors.

Ex-officio members of this committee shall include the president, the president-elect, the chairman of the Council, the immediate past president and the chairman of the Committee on Arrangements for the annual meeting."

Delete Section 3 and substitute a new section:

"Section 3. The Committee on Medical Service shall consist of five members and the President and Secretary-Treasurer of the Society, ex-officio. Its activities shall be carried on under the supervision and direction of the Council. Members of this committee shall be appointed by the Council for terms of three years; at the time of initial appointment, however, terms should be staggered with two appointed for three years, two for two years and one for one year.

This committee shall be responsible for informing the membership of all legislative matters of interest to the medical profession in the State of Illinois. It shall maintain surveillance of all bills introduced in the State Legislature having direct or indirect effect on the practice of medicine or of the health or sickness of the citizens of the State of Illinois.

The committee shall maintain effective liaison with the A.M.A. Committee on Legislation and the A.M.A. Washington office so that the Illinois State Medical Society will be fully informed and can perform as a vigorous member of the A.M.A. on matters of federal legislation.

The Medical Service Committee shall recommend a legislative program for approval of the Council and promulgate this program among the members of the Society. A report of its activities shall be submitted currently to the Council and annually to the House of Delegates."

There are no changes in conection with sections 4, 5, 6, 7, 8 and 9.

Add a new Section 10:

"Section 10. The Committee on Public Relations shall consist of six members. Members of this committee shall be appointed by the Council for terms of three years. At the time of initial appointment, however, terms should be staggered with two appointed for three years, two for two years and two for one years.

The committee shall prepare and submit a public relations program for the Illinois State Medical Society to the Council for approval.

Such a program should include public service projects of long and short durations, which will increase the public's esteem for the medical profession in Illinois."

Therefore, Chapter IX, Sections 1, 2, 3, and 10, as amended, will now read as follows:

"CHAPTER IX—COMMITTEES:

Section 1. The standing committees shall be as follows:

A Committee to Program the Annual meeting.
A Committee on Medical Service.
A Medico-Legal Committee.
A Committee on Medical Education and Hospitals.
A Committee on Medical Testimony.
A Committee on Medical Benevolence.
A Grievance Committee.
A Committee on Prepayment Plans and Organizations.
A Committee on Public Relations.

Section 2. The Committee to Program the Annual

Meeting shall consist of at least nine members, one-third to be appointed annually by the Council to serve a term of three years, except that when first constituted, three members shall be appointed for terms of three years, three for terms of two years and three for terms of one year.

It shall be the duty of this committee to coordinate the programs for the General Assemblies, the section meetings and the scientific exhibits at the annual meeting. It shall recommend to the Council a secret committee to make the awards to the scientific exhibitors.

Ex-officio members of this committee shall include the president, the president-elect, the chairman of the Council the immediate past president and the chairman of the Committee on Arrangements for the annual meeting.

Section 3. The Committee On Medical Service shall consist of five members and the President and Secretary-Treasurer of the Society, ex-offico. Its activities shall be carried on under the supervision and direction of the Council. Members of this committee shall be appointed by the Council for terms of three years; at the time of initial appointment, however, terms should be staggered with two appointed for three years, two for two years and one for one year.

This committee shall be responsible for informing the membership of all legislative matters of interest to the medical profession in the State of Illinois. It shall maintain surveillance of all bills introduced in the state legislature having direct or indirect effect on the practice of medicine or of the health or sickness of the citizens of the State of Illinois.

The committee shall maintain effective liaison with the AMA Committee on Legislation and the AMA Washington Office so that the Illinois State Medical Society will be fully informed and can perform as a vigorous member of the AMA on matters of federal legislation.

The Medical Service Committee shall recommend a legislative program for approval of the Council and promulgate this program among the members of the Society. A report of its activities shall be submitted currently to the Council and annually to the House of Delegates.

Section 10. The Committee on Public Relations shall consist of six members. Members of this committee shall be appointed by the Council for terms of three years. At the time of initial appointment, however, terms should be staggered, with two appointed for three years, two for two years and two for one year. The committee shall prepare and submit a public relations program for the Illinois State Medical Society to the Council for approval. Such a program should include public service projects of long and short durations which will increase the public's esteem for the medical profession in Illinois."

I move the adoption of this portion of the report. (Adopted)

Chapter X—Reference Committees: Delete Section 1. Add a new section as follows:

"Section 1. Appointment. Immediately after the organization of the House of Delegates at each annual or special meeting, the presiding officer shall announce the appointment from among the members of the House, such committees as may be deemed expedient by the House of Delegates. Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the presiding officer. These committees shall serve during the meeting at which they are appointed.'

I move the adoption of this portion of the report. (Adopted)

CHAPTER XI—COUNTY SOCIETIES:

Section 8. Delete in line 2-3: "and a list of the non-affiliated registered physicians of the county."

Section 8. Delete in line 11: "In making his annual report he shall account for every physician who has lived in the county during the year."

Section 9. Delete in line 4: "and a list of non-affiliated physicians of the county."

So that Chapter XI, Sections 8 and 9, as amended, will now read as follows:

"Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster, the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the councilor of the district in which his county is situated.

Section 9. The secretary of each component society shall forward its assessment together with its roster of officers and members, list of delegates, to the secretary of this Society before the first of April each year."

I move the adoption of this portion of the report. (Adopted)

I now move the adoption of the report as a whole as amended. (Adopted)

Your committee wishes to thank the members of the Constitution and Bylaws Committee, Dr. W. C. Bornemeier, Dr. Andrew Brislen and Dr. Arthur Goodyear for the advice and recommendations given during the open hearing.

We also wish to thank Mr. Walter Oblinger, legal counsel, for his opinion in relation to various necessary legal decisions.

We wish to also thank the entire membership of the Secretary's office for their consideration and secretarial help in preparing this report.

I also want to thank Dr. Heerens for appearing with us and coming to meet with us so that we could reach a decision on the proposed amendments that he presented.

The Chairman wishes to thank the members of his committee, Dr. Solomon L. Goldberger, Dr. James H. Rutledge, Dr. Fred A. Tworoger and Dr. N. A. Thompson, who so efficiently aided in the phrasing of the various sections and changes as noted in this report.

THE PRESIDENT: The chair wishes to personally thank you for a job well done. I am very proud of you, Bill. It was a terrific task and I am sure that the House shares my feeling in that regard.

DR. J. D. MILLIGAN: I would like to ask for clarification from the legal counsel on the vote that was taken by the House of Delegates on the report of Reference Committee No. 2. In that connection I have reference to the last paragraph, wherein they referred all of the resolutions to a committee for study.

I think that what they voted on was this—that Dr. O'Neill made the statement that the committee be appointed within the Council to review this. If that is what we voted for, then I would make a motion, if this is in order legally, that we have a committee of delegates with the committee of the Council to review this.

THE PRESIDENT: If the chair made such a statement, it was in error and if he did, your motion is entirely in order. I will so rule. Is there support for the motion made by Dr. Milligan? (Seconded)

DR. BREED: Who are they going to report to?

THE PRESIDENT: The House of Delegates, I presume.

Dr. Milligan, I believe that several of the delegates did not hear your motion. I request that you again state it.

DR. MILLIGAN: I make a motion to review this entire program of the aged as reported by Dr. Hirsch's committee; that a committee be appointed, as Dr.

Hirsch suggested, by the Council; that the committee be diversified, and that a committee of delegates meet with the committee of the Council for this purpose.

THE PRESIDENT: Do you have the motion now—are you ready for the question?

MEMBER: Do you have the motion on record the way that it was voted a while ago?

THE PRESIDENT: The report which the reference committee rendered and which you adopted says: "Your reference committee therefore recommends that the House of Delegates request the Council of the Medical Society to refer the substance of these resolutions to a committee for full review, analysis and recommendations to the Council for appropriate decision."

DR. MILLIGAN: That is right. Your statement, when you read it, was that the committee was within the Council.

THE PRESIDENT: I did not read that but we will see whether that is correct from the stenographic statement when rendered. However, that is the substance of the resolution, that the committee be appointed and that the analysis and recommendations go to the Council for appropriate decision. I think that your motion is entirely in order.

DR. L. S. TICHY: This report was adopted as a total report. Doesn't the printed word prevail within the report after adoption of the total report?

THE PRESIDENT: It does.

DR. TICHY: Then this clarifies the issue.

THE PRESIDENT: The position of the chair is that he may have erred in saying that this was a decision to be made within the Council and that was not the substance of the report.

DR. MILLIGAN: I will withdraw the motion if that is what it is.

DR. M. MIJANOVICH: As long as we are dealing with constitutional amendments and the McHenry County resolution regarding constitutional amendments, I feel that it is necessary to inform you that in discussing the McHenry County resolution Dr. Montgomery felt that it might interfere with some of the reorganizational programs that we are now going through within our society. He felt that if this were passed and were to interfere with the organizational program it might not be of benefit to the state society.

This I would not approve of any more than any other member of this organization. However, I feel that it is not very democratic to have taken the action that this body did take and I feel that this resolution should be heard and should be discussed. It should probably be referred to the Committee on Constitution and Bylaws for study and report during the ensuing year and then brought back to this body next year.

I would therefore like to make a motion to take from the table the resolution of the McHenry County Medical Society. (Seconded)

THE PRESIDENT: The motion is simply that the matter of the resolution of the McHenry County Medical Society be removed from the table. It has been seconded. It requires a majority vote to remove this from the table. Are you ready for the question. (Carried)

DR. MIJANOVICH: If Dr. Montgomery will withdraw his motion not to consider this resolution, I should like to supplant it with a motion to consider this resolution as a committee of the House—this body to consider it as a committee of the whole and to recommend a referral to the Constitution and Bylaws Committee for study and recommendation at the annual meeting next year.

THE PRESIDENT: I think that there is some parliamentary procedure involved in that but the chair will overlook it. I think that to refer to the House as a whole requires a two-thirds or unanimous vote. However, this whole matter of the motion and the matter pertaining to the motion was tabled in toto and this motion, in the opinion of the chair, cannot be withdrawn by Dr. Montgomery but you may vote to reconsider it.

MEMBER: I would like to rise to a question and possibly a point of order. The doctor who is at the rostrom has made a motion to refer—he has actually made two motions to refer. He first suggested that it be referred to a committee of the whole and then, in the same sentence, to the Constitution and Bylaws Committee.

I think that were he to reword his motion to refer to either, his motion then would take precedence because it is a motion to refer.

THE PRESIDENT: Possibly you will rephrase your motion.

DR. MIJANOVICH: I don't believe that is quite in order. If I am not mistaken, the resolution at present has Dr. Montgomery's unacted upon motion attached to it. Therefore, any other motion would be out of order, would it not?

DR. BRISLEN: I would interpret it as meaning that you are asking to have this whole matter referred to the Constitution and Bylaws Committee or to the committee as a whole. You have made a motion right now that this be referred to the committee as a whole and to the Constitution and Bylaws Committee and these are two opposing motions.

DR. MIJANOVICH: When we take the matter from the table then there is already a motion from it before the House and that motion is Dr. Montgomery's motion not to consider.

DR. BRISLEN: That is true but it is a subsidiary motion and yours is also a privileged subsidiary motion because yours is one to refer.

DR. MIJANOVICH: Then I shall move that we refer this to the Committee on Constitution and Bylaws for study and report at the next House of Delegates. (Carried)

Reference Committee on Reports of Council Committees, No. 4

Dr. Maurice Murfin, Chairman.

Your Reference Committee on reports of Council Committees #4 has met in executive session following the open hearings held Tuesday morning, May 24, 1960, and submits the following report:

ETHICAL RELATIONS COMMITTEE:

The Ethical Relations Committee for the second consecutive year reports no cases and during the past year held no meetings. The committee is grateful to note the good standing of affairs within the society.

I move the adoption of this portion of the report. (Adopted)

FIFTY YEAR CLUB COMMITTEE:

The Reference Committee reviewed the report of the Fifty Year Club Committee and notes with pleasure the activities of this club. The membership of the club now totals approximately five hundred physicians, and sixty-five members of the Society will become eligible for membership during the coming year. May we again congratulate Dr. Andy Hall for his work in behalf of the Fifty Year Club members.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON INDUSTRIAL HEALTH:

The reference committee reviewed the report of the Committee on Industrial Health and highly commends this committee for its successful campaign in behalf of the impartial medical testimony project. The Illinois State Medical Society will be forever grateful to Dr. R. J. Bennett, Chairman of this committee. Dr. Bennett has done a tremendous and commendable job of pioneering this project. It is noted that on November 24, 1959, the Council of the Illinois State Medical Society appointed a new Committee on Impartial Medical Testimony to carry on the program so ably initiated by the Committee on Industrial Health.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY:

The reference committee has reviewed the report of the Impartial Medical Testimony Committee and notes a fine presentation of a progress report. Dr. S. A. Levinson and his committee have already made excellent progress in carrying on this important new program.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE TO COOPERATE WITH THE ILLINOIS HOSPITAL ASSOCIATION:

The reference committee reviewed the report of the Committee to cooperate with the Illinois Hospital Association and recommends the report be accepted as printed.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON INSURANCE:

The reference committee received no report from the Insurance Committee and no members appeared at the open hearing in behalf of this committee.

I move the adoption of this portion of the report. (Adopted)

MATERNAL WELFARE COMMITTEE:

The reference committee reviewed the report of the Maternal Welfare Committee. We highly commend Dr. Frederick Falls and his committee for such a well balanced program. The Committee appreciated Doctor Fall's excellent report and was pleased to note the amazing result. The committee feels that the entire House of Delegates should have heard his presentation.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON MEDICAL ECONOMICS:

The reference committee reviewed the report of the Medical Economics Committee. The committee continues to submit active and timely articles to the editor of the Journal. The committee urges all members to read the publications.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON NARCOTICS:

The reference committee received the supplementary report in addition to the published report of the Narcotics Committee. A supplementary report directed as Resolution #35 was carefully studied. The Committee concurs with the meaning of the resolution and recommends its acceptance.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON NECROLOGY:

The reference committee notes that a Committee on Necrology actually does not exist and that a report prepared by the secretary's office was submitted. This report included the deaths of members of the society reported to the Secretary's office since the last annual report.

The committee thanks Jane Swanson of the Secretary's office for the preparation of this report.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON MEDICAL LICENSURE:

The reference committee reviewed the report of the Committee on Medical Licensure as presented by Dr. James Hutton. The committee is in full agreement with this report.

I move the adoption of this portion of the report. (Adopted)

RESOLUTIONS 23, 24, 25-PEORIA COUNTY MEDICAL SOCIETY:

The reference committee reviewed resolutions 23, 24, and 25, as prepared by the Peoria County Medical Society. Your committee agrees with the general spirit of such resolutions. However, we have taken the liberty of drafting resolutions 23 and 25 into the following statement of policy and herewith submit to you for approval:

"The Illinois State Medical Society firmly opposes socialism in all of its forms. The compulsory health schemes, which the welfare state planners are promoting at this time, are examples of socialism which not only the medical profession but the public must vigorously oppose."

I move the adoption of this portion of the report. (Seconded)

DR. DOLAN: I believe that the committee has taken a little too much liberty in combining these resolutions #23 and 25.

For example, in Resolution #23, one of the Resolved" clauses is that the 224 members of the Peoria Medical Society have voted to oppose all compulsory and third-party controlled medical care. I wonder if the committee meant to leave that out—all third party medical care?

If they did mean to leave it out, I am wondering if they would mind including it.

THE PRESIDENT: Would you like to answer that, Dr. Murfin?

DR. MURFIN: I don't believe that I should take the liberty inasmuch as we were in executive session at the time. If another member of my committee, and I see that one of them is asking for the floor, would do so, I would be glad to have him comment.

DR. HARRY MANTZ: I would like to answer the question by stating this: that in the committee we did not feel that the Peoria people really meant what they said, that they want to oppose all third party controlled medical care.

We took this to mean that you did not believe in insurance at all and, of course, all legitimate insurance is a third party and, of course, we therefore did not feel that this was a proper statement.

DR. DOLAN: Actually, I think that all of us must be opposed to third party medical care. When one speaks of indemnity as opposed to a service type of policy, then it makes quite a bit of difference and I think that indemnity type of policies do not interfere with medical care, whereas I believe that almost everyone must be agreed that the service type of policy does.

That, to come to the point of it, is the essential difference.

DR. MANTZ: This is not what this resolution says. You don't differentiate between legitimate insurance and conventional insurance. You merely damn them all with the term "third party medical care." However, the term, insofar as we were concerned, was too broad and we felt that our statement of policy was simple and to the point; that it points out that we do not approve of socialism of any kind and that we in particular do not approve of these compulsory schemes which the politicians are trying to put upon us.

We felt that the same statement of policy embodied the first and third Peoria resolutions.

DR. DOLAN: Would it be in order to ask one of the Peoria delegates to clarify this and I will accept it if they say that they in turn agree with the interpretation of Dr. Mantz.

DR. HART: At the time these resolutions were drafted I don't believe there was any criticism directed to the established prepayment insurance policies, nor was there any intent of classifying them as third party members in the patient-doctor relationship. I think that we all know the basic point toward which we are driving and I hope that we will establish and make our stand forceful so that not only the public but also those in Washington know exactly where we stand.

DR. SAXON: I just want to point out the essential difference. It is a matter of interpretation as to whether fixed fee medicine of any sort, even partially or other-

wise, constitutes socialism or whether it doesn't.

I must remind the house that already we have approved a Blue Shield plan for the fixed fee and in connection with this part of the Illinois State Medical Society policy, if we were to adequately oppose this at this particular time, we would have to rescind the action of the Illinois State Medical Society in proposing this plan. This would make a rather bad situation. We do not wish to disgrace our state medical society by proposing at this time any fixed plan, although we in Kendall County have totally disapproved of this action. However, we feel that probably the integrity of the society should be preserved.

However, we would condemn as a matter of policy any further continuation of fixed fee medical insurance.

(The question was called for. Carried.)

DR. MURFIN: We come now to the statement pertaining to Resolution #24.

The reference committee notes that Resolution #24 is similar in thought and purpose to resolutions already submitted and under study by Reference Committee #2. Your committee sought and had consultation with Reference Committee #2 and concurred with their final actions recommending that the House of Delegates request the Council of the medical society to refer the substance of this resolution to a committee for full review, analysis and recommendation to the Council for appropriate decisions.

I move the adoption of this portion of the report. (Adopted)

I wish to thank the members of this committee for their fine cooperation, advice and counsel in the preparation of this report.

I move the adoption of the report as a whole. (Adopted)

Reference Committee on Reports of Council Committees, No. 5

Dr. William L. Whiting, Chairman

COMMITTEE ON NURSING:

The reference committee considered the report of the Committee on Nursing, had the privilege of extensive discussion with the committee chairman and studied the supplementary report submitted prior to the first meeting of this House. As pointed out in the supplementary report, the problems of nursing continue. We were fully aware of the sincere and dedicated work done by the Committee on Nursing but also that the same problems continue to plague us and apparently will do so always. The problems of nursing recruitment continue and because the needs of the profession are changing, the difficulty in getting young women interested in the nursing profession has become quite acute. It appears now that the requirements for a degree in graduate nursing have become so exacting that while the demand for trained personnel grows, the number graduating decreases. It is probable that in time that all of the degree nurses will be used in supervisory and instructional positions. It is apparent that others must perform the essential bedside care. It is suggested that the Committee on Nursing look into the possibilities of encouraging the training of more diploma nurses to fill this need.

Your reference committee is in agreement with the conclusions of the Nursing Committee, but would like to emphasize three points that may promote these efforts:

1. That the members of the Illinois State Medical Society, the auxiliary and component societies continue to recruit individuals for the vacancies in training schools.

2. That the Illinois State Medical Society continue its efforts to solve the problem foremost in the concern of all physicians, the adequate provision of trained personnel to provide bedside care.

3. Finally, we reiterate a recommendation made by this Reference Committee in 1959, that we recommend that the Council of the Illinois State Medical Society consider and possibly assist in the presentation of a bill to establish present three-year hospital schools of nursing as three-year colleges of professional nursing so that the individual student may transfer three years credit to the college of her choice to complete study and receive a Bachelor of Nursing degree.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON NUTRITION:

Your reference committee was privileged to have the chairman of the Committee on Nutrition, Dr. Paul A. Dailey, present to emphasize the important work which they have done. Noting the activities recorded in the report and hearing about anticipated programs for the coming year, we felt that the Committee on Nutrition deserves to be highly commended for effective promotional effort in a signally important and rapidly developing field of great import to medicine.

Dr. Dailey announced that another Joint Conference on Nutrition co-sponsored with the Illinois Nutrition Committee is to be held October 8, 1960 at Normal, Illinois. He advised that the Committee on Nutrition would like very much to have the local county society also participate in the sponsorship of this conference. We agree in this suggestion and urge the county society to do so and, also, recommend to this House and the doctors of Illinois that as many as possible attend and take part in the Joint Conference October 8, 1960, at Normal, Illinois.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON PHYSICALLY HANDICAPPED CHILDREN:

In reviewing the report of this committee and the discussion in the reference committee meeting, we were impressed by the rapidly advancing multi-disciplined approach that is being applied to the problems of the handicapped child. In the past, the remedial programs concerned themselves primarily with orthopedically crippled children. In recognition of the multiplicity of defects that produce physical, mental and socio-economic handicaps the approach to the total problem of the child is impressive. We urge this committee to continue its good work and to report to this society on the progress as it encompasses all of the problems of the handicapped children of the State of Illinois.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON POLIO CONTROL:

Your reference committee had the privilege and pleasure of consultation with the chairman of the Committee on Polio Control, Dr. J. L. Reichert, to amplify the report as published. We would like to call to the attention of the House of Delegates and through them all of the physicians of the State of Illinois several important aspects of the prophylaxis of poliomyelitis.

1. There is commendable increase in the utilization of Salk vaccine immunization. It appears that the potency of materials available is increasing and, therefore, an increase in effectiveness is to be expected.

2. Annual polio shots are now recommended irrespective of the number previously administered to realize the fullest protection.

3. Although the oral live virus material is not generally available, the impressive results obtained by the broad pilot programs administered all over the world would indicate that this is to be an effective addition to the prevention program.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION & SCIENTIFIC SERVICE:

Your reference committee was encouraged to note that this committee continues to render a useful service

although its program is limited to only a small part of the potential of the State of Illinois.

In consideration of the change of administration of the Illinois State Medical Society and the much closer liaison with all component societies, it is hoped that a fuller utilization of the services of the committee will be possible in the future. Dr. Louis R. Limarzi, chairman of the committee, indicated that a broadened program is planned and that this will be appropriately implemented after the reorganization is complete.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON RADIATION:

Your committee was disappointed to find so brief a report from the Committee on Radiation. There is no doubt that ionizing radiations both from machines and nuclear disintegration are becoming more important. The possible danger to human life and health must be carefully considered. The tendency for great exaggeration in the press tends to produce unwarranted fear which in itself does great damage. The committee is urged to actively cooperate with the AMA committee now investigating radiation so that we may be kept fully informed of recent discoveries and recommendations in this area.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON RURAL HEALTH AND THE STUDENT LOAN FUND:

The reference committee found it interesting and gratifying that a full awareness of the needs of rural medical care are so well recognized and considerately promoted by this council committee. Dr. Harlan English, chairman, attended the open meeting and commented on the problems of the loan fund. Although it is recognized that disappointments will occur in relation to a very small number of individuals, the impressive number (87) of new country doctors added to our roster through this program far outweighs these. We feel that the committee is to be commended on its total program and that the loan fund is to be congratulated for careful and effective administration.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON SCHOOL HEALTH:

The report of the committee, as recorded in the Handbook and printed in the April number of the Illinois Medical Journal should be read by all physicians to gain knowledge of the problems of school health. Dr. W. W. Fullerton, chairman, attended the committee meeting. He pointed out a transcription error in the printed report that should be noted. In the second portion of the second paragraph the statement concerning supervision of contact sports in the school systems should be changed to read as follows:

"It was further brought out that probably supervision in the school systems was bad in most instances. In further emphasis of this your committee would like to call to the attention of all physicians two recommendations in the Illinois Report of the 1960 White House Conference on Children and Youth. Page 43. (7) Schools should not include body contact sports, particularly tackle football and boxing, in programs for children of school age through the ninth grade. Developmental needs of elementary school children are best met if physical activities are informal and not highly competitive. Children of elementary school age are particularly susceptible to bone and joint injury. Adequate medical supervision of all school athletic programs is essential. (8) Agencies sponsoring athletic activities outside of school programs should be required to provide for competent medical supervision."

Dr. J. L. Reichert attended the committee meeting to explain some features of the Chicago school health program. He pointed out four goals to be worked toward in the Chicago program:

1. All children should enter school with a complete physical and mental evaluation of their abilities and needs.

2. Where it is needed remedial programs must be instituted privately or publicly for the children of the indigent.

3. Except for those carefully screened children of the indigent, the examinations will be performed by private physicians.

4. Both private and needed public examinations should be performed in the appropriate medical atmosphere of office or clinic and not in the schools.

I move the adoption of this portion of the report. (Adopted)

COMMITTEE ON TRAFFIC SAFETY:

Your committee is well aware, as we feel are all physicians, of the important problems of traffic safety. Dr. F. Garm Norbury was present at the meeting to detail the origin of his interest and to report that the research program begun in this state is making some progress. We would recommend that all members of the Illinois State Medical Society do all in their power to promote this effort.

I move the adoption of this portion of the report. (Adopted)

REPORT OF THE ILLINOIS CHAIRMAN, AMERICAN MEDICAL EDUCATION FOUNDATION:

It is the confirmed consensus of this reference committee that all members of the Illinois State Medical Society should be pleased and exceedingly proud of the significant total contribution by this organization to this necessary service. We would like to recommend that all members of this House examine carefully the exhibit on the AMEF and note the real importance of the Illinois participation.

I move the adoption of this portion of the report. (Adopted)

RESOLUTIONS

ADAMS COUNTY MEDICAL SOCIETY #1:

We commend the Adams County Medical Society for an effective promotional and implemented effort in this most worth while activity and move the adoption of this resolution. (Adopted)

KENDALL COUNTY MEDICAL SOCIETY (1) #3:

We are in sympathy with the philosophy implied in the resolution and confident that the profession is concerned with the unfortunate efforts toward government control of medical practice. In view of the known opposition of the profession to socialism, we do not believe the adoption of this resolution is necessary. We move that this resolution not be adopted. (Seconded)

DR. SAXON: This was our #1 resolution, which had a distinct purpose and, personally, I feel that this society and House of Delegates should adopt it. I say that it is the number one resolution and it is too bad that we could not have had them combined under one committee. However, this has a special principle all of its own, namely, that in it we quote the constitutional right and permission and we actually feel that it is mandatory on the part of this society to take a stand against socialism on the basis that it affects medicine.

In connection with the report of the reference committee, they are concerned with the effort toward governmental control of medical practice. Sure, we all object to socialized medicine. This is a broad term but then this is a very specific item designated to our constitution and in connection with which our Political Action Committee will have some teeth in opposing the socialization of medicine according to our constitution and bylaws.

I would therefore move that we reconsider the adoption of this resolution.

DR. WHITING: I would like to make some slight amplification of our own consideration of this.

I would first of all like to point out that Dr. Saxon in his resolution implies the etiology of physical and

mental disease as socialism. Frankly, we did not feel that we wanted to enter into a discussion of this kind since there are undoubtedly others who would imply the same thing for capitalism, communism, etc. We therefore felt that his implication was only that in opposition to socialism and that perhaps he had not intended the meaning quite as we interpreted it.

THE PRESIDENT: Is there further discussion? Dr. Saxon, I am aware that you made a motion but I did not hear any second. (Seconded)

THE PRESIDENT: Is there any discussion of the motion to reconsider?

(The question was called for, the motion voted upon and carried.)

DR. SAXON: I would move that we amend the report to approve of this resolution. (Seconded)

THE PRESIDENT: It has been moved and seconded that we amend the report to approve the resolution. Is there discussion? You are voting now on an amendment to approve the resolution in opposition to the position which the reference committee took. Is the chair straight on that? You are voting to approve the resolution.

(The amendment was voted upon and lost.)

THE PRESIDENT: We are now back on the original motion of the reference committee, to not adopt the resolution.

(The motion was voted upon and carried.)

DR. WHITING: We come next to the resolution introduced by Dr. W. O. Ackley concerning examinations for Airmen's Certificate Class 3, Resolution #34.

A very detailed discussion of the background and import of this resolution was presented by Dr. Leo Sweeney, who took part in the writing of the original AMA resolution. It was emphasized that any interested competent physician could apply and be certified to perform this examination. It was not the belief of this committee that any further action was necessary by this House of Delegates.

We move that this resolution not be adopted. I move the adoption of this portion of the report. (Seconded.)

DR. ACKLEY: I would like to say that one of the more severe indictments against medicine was made by the FAA when it said that eighty-four per cent of all the people that it examined and re-examined were disapproved. The charge against us is that doctors are either incompetent or dishonest, one of the two. So far as the ruling that they have made goes, that is to be modified.

The thing about this is that any time that you falsify a record, a copy of which goes to the FAA in Washington, it is a year in jail or a fine of $10,000.

As far as the second part of this examination being sent to the FAA is concerned, if the FAA issues a license, then that is the FAA's responsibility because they have that individual's report in front of them.

Now, I have been talking the socialization aspect and I think that what will actually happen is that they will give it to everyone and then, over a period of time, start cutting down and the first thing you know they will have a small compact unit.

I would like to move that some action be taken on this thing rather than no action.

DR SWEENEY: I sat in on the writing of this resolution in Dallas and one of the men who came before the committee at that time was the first air surgeon for this new Federal Aeronautics Administration. He appeared there, as well as two or three other men who were vitally interested in this. I was led to believe that no physician is prohibited from making these examinations if he will tell the administration beforehand that he is interested and is duly licensed.

Of course, there are many unqualified people making these examinations. I am sure that there is no thought on the part of the current medical director of the Aeronautics Division to curtail activities of the private physicians.

Any interested and duly licensed physician can get permission to make these examinations.

DR. J. R. O'DONNELL: I happen to be personally interested in this. I am a member of the Flying Physicians Association.

I disapprove of the board examining any interested or competent physician because just recently I examined a man as a general practitioner and he was classified as having intermittent hypertension. I received a letter back saying he would subsequently have to go to a specialist of the Board of Internal Medicine for approval. They gave him a temporary certificate for thirty days. I wrote to the FAA and received a letter back saying that under the circumstances I was an interested person because I am the family physician for this man and therefore they wanted a disinterested individual to examine this patient. This implied to them that perhaps I was dishonest. This, of course, is what I object to.

I feel rather strongly that any individually licensed physician in the State of Illinois is competent to do this type of work.

THE PRESIDENT: The motion is not to adopt the resolution. (Carried)

DR. WHITING: I would also like to point out that all the members of this committee took an active and constructive part in its deliberations, to thank all of them for their participation and also to thank all of the interested physicians who contributed so much to our conclusions by their thoughtful discussions in meeting.

I now move the adoption of the report as a whole. (Adopted)

THE PRESIDENT: The chair is not certain whether the supplementary report of the Committee on Reports of Officers, Councilors and Delegates was introduced and adopted.

DR. CALLAHAN: It was not.

THE PRESIDENT: Will you then present it.

DR. CALLAHAN: This is in connection with a review of the supplementary report by the Chairman of the Council on the subject: "The Relative Value Study."

Our committee studied this report and makes this recommendation: That this supplementary report be referred to the Council and its appropriate committee and, in the words of the report "consider and study this matter more fully and to arrive at some recommendations," with a report to be ready at the next House of Delegates.

I move the adoption of this supplementary report. (Adopted)

THE PRESIDENT: Dr. Hamilton wishes to make a report under unfinished business.

DR. HAMILTON: As you know, we have made a great effort to send out letters to the members of the Ways and Means Committee who are down at Washington in connection with the matter mentioned at our first meeting. We have sent out some two or three hundred since we have been down here. However, if there are some of you who may not have done so, we would appreciate it very much if you would write to one of the two men mentioned the other evening.

We heard just a few moments ago that action by the Ways and Means Committee has been postponed until next Tuesday and so that will give us another three or four days in which to try to exert all the pressure that we can.

THE PRESIDENT: Is there any further unfinished business? Is there any new business? Under this item I would like to have the permission of the House to grant the privileges of the floor to the new administrator, Mr. Richards, who wishes to read a statement to you that is very short.

MR. RICHARDS: May I first comment that you are to be congratulated upon the progressive and enlightened action which you have taken today. As a preliminary step in the planning program, the Council has approved the implementation of District Councilor meetings during the coming year. These meetings will be used to have staff directors discuss with your members the problems which are facing them. More details will be made available to you at a later date. In the meantime, do not forget that

we welcome your constructive criticisms and suggestions.*

With the permission of the President, I should like to have Mr. Neal comment upon this arrangement.

MR. NEAL: I have not planned this appearance for as recently as thirteen hours ago it had not occurred to me that it would be necessary. However, as Bob pointed out, if note were taken of this administrative change, some of you might possibly go away thinking we had wasted no time getting into a disagreement.

I would like to say that this change is something that I have thought about for some time and the initiative rests entirely with me. I first made the suggestion to the Chairman of the Council more than a month ago and later discussed it with Mr. Richards. It seemed to me an acceptable and reasonable administrative change in view of the reorganization. It is nothing more than an attempt on my part to facilitate that reorganization to the highest possible degree. Apparently my suggestion has met with approval. This, of course, pleases me.

As you know, I have always served at the pleasure of the Council and the House of Delegates. In another couple of hours there will be a new Council and if it is your pleasure that I continue to serve in the suggested new capacity, then I shall be very happy and very much honored.

THE PRESIDENT: Is there any other new business to come before the House? Hearing none, it has now come to the time when the new administration will be inducted into office and the old one goes on its creaking way.

This has been a wonderful year—all too swift in passing at some times and all too dragging at other times, according to the mood of the individual. I have enjoyed it immensely and I have appreciated deeply the honor which was bestowed upon me. I have tried to cover the duties of the president efficiently, and I hope that I have succeeded in some small way. It is a particularly high office and carries with it a terrific obligation.

I want to thank you for the opportunity of having been able to serve you during the past year. I shall never forget the memories of the year. I hope that I have conducted myself as well as my limited capacity permits.

Thank you again and I shall long remember my experiences here.

May my applause also go to you for the tact and temperate conclusions which you have indulged in during the three sessions of this House. It has been a joy to preside at each. I have not had to rap the gavel too many times but there is nothing personal when I do this—it is simply my decision and my judgment.

(At this point the incoming President and his wife were conducted to the rostrum.)

THE PRESIDENT: My friend, Close, I don't know of anyone I would prefer transferring the tools of this office than to you. For a great many years, I have known you personally and then administratively from our service in the Council, and I know that the affairs of the Illinois State Medical Society are going to be in wonderful hands this year.

I am going to transfer to you for the coming year the Barney Oldfield Memorial Medallion which I know that you will proudly wear. With it goes this badge of authority, the gavel of the society and also my kindest wishes for a successful year.

PRESIDENT HESSELTINE: The comments that you made, Dr. O'Neill, were most generous. Perhaps one may think it is easy to walk down that aisle, especially when you have done it many, many times before under different conditions. However, I suspect that even the most frequent curtain calls do not give the actor the gratification that you would feel at this particular moment.

All means of communication contain deficiencies for me to express to you my sincere thanks and great elation in becoming your president. Any words that I may offer seem shopworn or inadequate. However, I must say, no greater honor could you give to any member. Honors should be balanced by responsibility, therefore, I pledge to you that I shall do my best for the Illinois State Medical Society and the purpose for which it exists. Every effort will be exerted to continue to maintain this office during my term in its traditional dignity and yield it to my successor free from tarnish or stain.

On further thought, I am sobered by the fact that if it were not for me someone else would be here in my place. After evaluation of various factors, the most favorable odds for a member of the Chicago Medical Society to become president of our society rests in the ratio of one to five hundred. This is another reason why I am humbled by your generous act.

I have a few comments to make but before going into them I would like to ask my lady, Gracie as I call her, to just stand so that you may see her. Will you please stand.

I promise you that the few comments that I should like to make will take but very little time. You have heard much better oratory during the meeting and, therefore, this is not in any way in competition.†

There were some new officers elected this morning and I would like the privilege of the House to have these officers come forward. We know them but then I think that we owe them that courtesy.

President-elect, Dr. Hamilton.

First Vice President, Dr. Brislen.

Second Vice President, Dr. Swisgard.

Secretary-Treasurer, Dr. Riss.

We also have an Executive Administrator Protem, Dr. Lull.

I would also like to have his successor stand, Mr. Richards.

Is there any further business to come before this House? If not, I will entertain a motion for adjournment sine die.

(Whereupon, in accordance with regular motion, at 12:40 o'clock, p.m., the meeting of the House of Delegates adjourned sine die.)

*See August Journal, P. 98, for this report.

†See July Journal, P. 25, for Presidential Address.



The physician listens to a tense, nervous patient discuss her emotional problems. To help her, he prescribes Meprospan® (400 mg.), the only continuous-release form of meprobamate.



The patient takes one Meprospan-400 capsule at breakfast. She has been suffering from recurring states of anxiety which have no organic etiology.



She stays calm while on Meprospan, even under the pressure of busy, crowded supermarket shopping. And she is not likely to experience any autonomic side reactions, sleepiness or other discomfort.



She takes another capsule of Meprospan-400 with her evening meal. She has enjoyed sustained tranquilization all day—and has had no between-dose letdowns. Now she can enjoy sustained tranquilization all through the night.



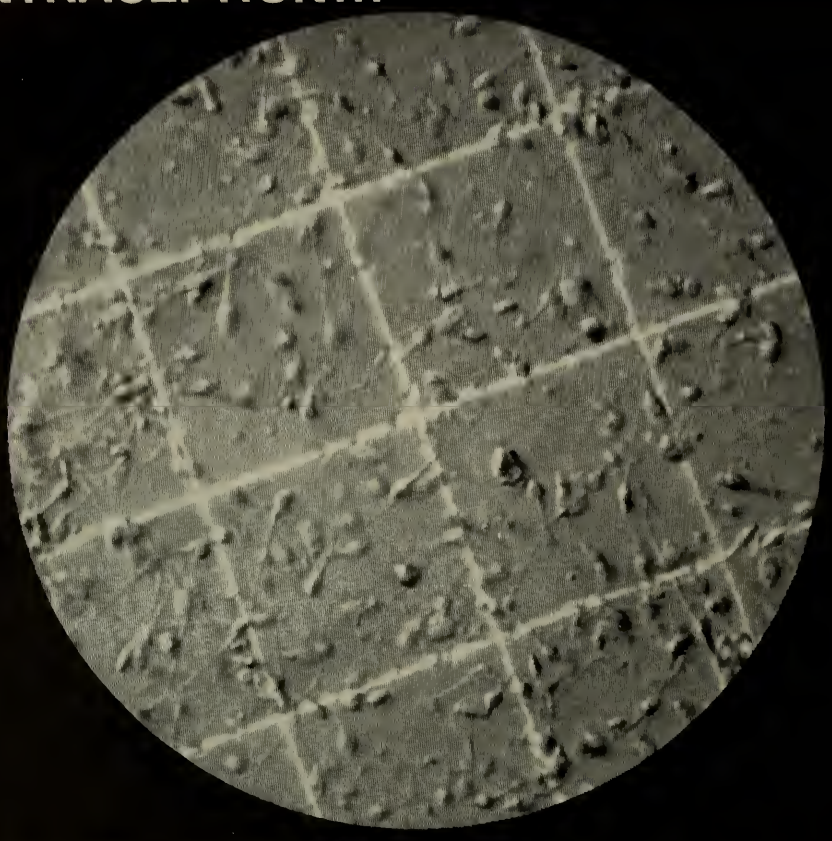
Relaxed, alert, attentive . . . she is able to listen carefully to P.T.A. proposals. For Meprospan does not affect either her mental or her physical efficiency.



Peacefully asleep . . . she rests, undisturbed by nervousness or tension. (Meprospan samples and literature available from Wallace Laboratories, Cranbury, N. J.)

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IN CONTRACEPTION...



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WHY IS DIFFUSION IMPORTANT?

Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this *dual* protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel — in minutes — a decisive measure in conception control.

In Lanesta Gel *7-chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. The addition of 10 per cent NaCl in ionic form greatly accelerates spermicidal action. Ricinoleic acid facilitates rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



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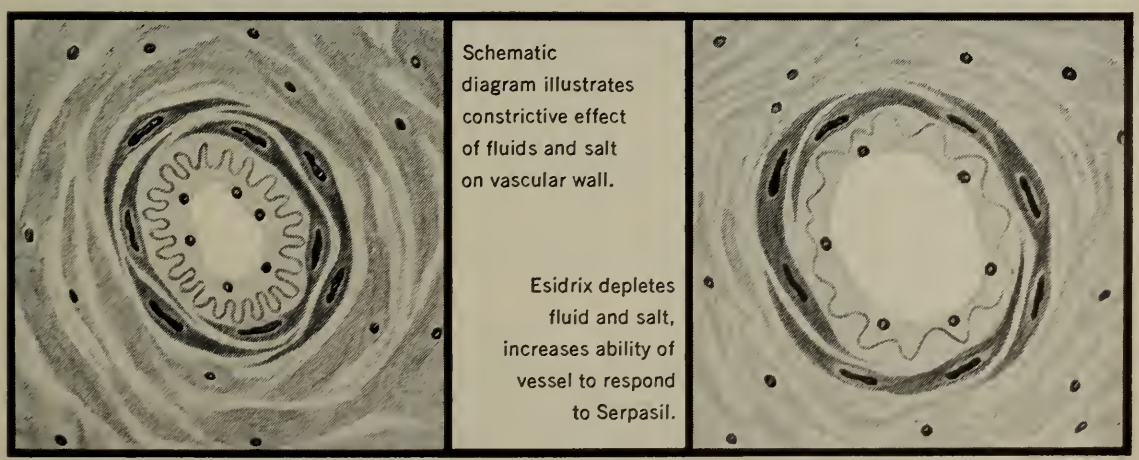
Supplied: Lanesta Exquiset® . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

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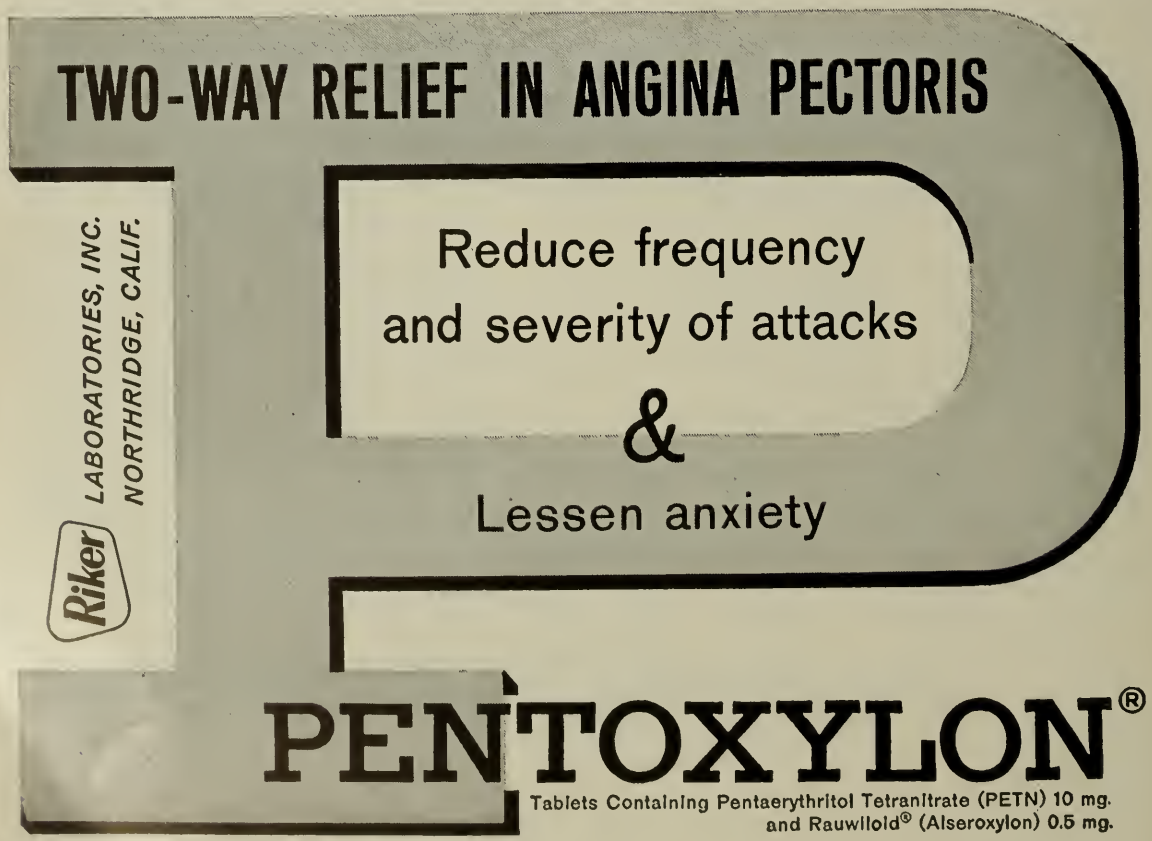
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Diagnosis ala mode

I would beg your indulgence for the description of a curious misuse of elegance to which I was exposed as a medical student. I arrived at the Johns Hopkins Medical School in 1911, during the heyday of physical diagnosis. At a time when biochemistry was discussing the structure of nucleic acid, clinical medicine was presenting physical diagnosis as an independent discipline which had made little sophisticated progress in the many years since Auenbrugger and Laennec. Physical signs were collected with less interest in their relevancy than in the virtuosity by which they were obtained. Elegance was the keynote of percussion; in vain did I try to develop the graceful wrist action that would have been more appropriate to Paderewski's piano playing. It was not sporting to look at a chest x-ray until the patient had been worn out by a tiresome period of physical diagnosis, and much time was spent on estimating the blood pressure by palpation before the sphygmomanometer was applied, although the inaccuracy of palpation had long since been proved. As I look back, I realize that it was a misuse of elegance to draw a clef and place the heart murmurs on it in absolute pitch. Holmes, in 1844, observed that "the errors of stethoscopists spring much oftener from faults of their brains than of their ears." Physical diagnosis went through a painful adolescence before it became the useful but less important technic of today. But I envied the elegance of my instructors, and suffered from my inability to emulate it. *Dana W. Atchley, M.D., The Uses of Elegance. Ann. Int. Med. April 1960.*

Victorian hallmarks

Haemorrhoids are said to have been one of the three essential adjuncts and afflictions of the successful Victorian physician. A paunch was his hallmark of well-merited affluence, baldness gave him an air of experience and wisdom, and haemorrhoids ensured a look of constant anxiety. We can pride ourselves of having shed both the substance and the meaning of the first; we are casting doubt on the interpretation of the second; but we remain faithful to the third. Haemorrhoids is still a disease of the professional classes; it deserves the interest—but is often accorded the neglect—of a doctors' ailment. *Haemorrhoids. The Lancet. Feb. 20, 1960.*



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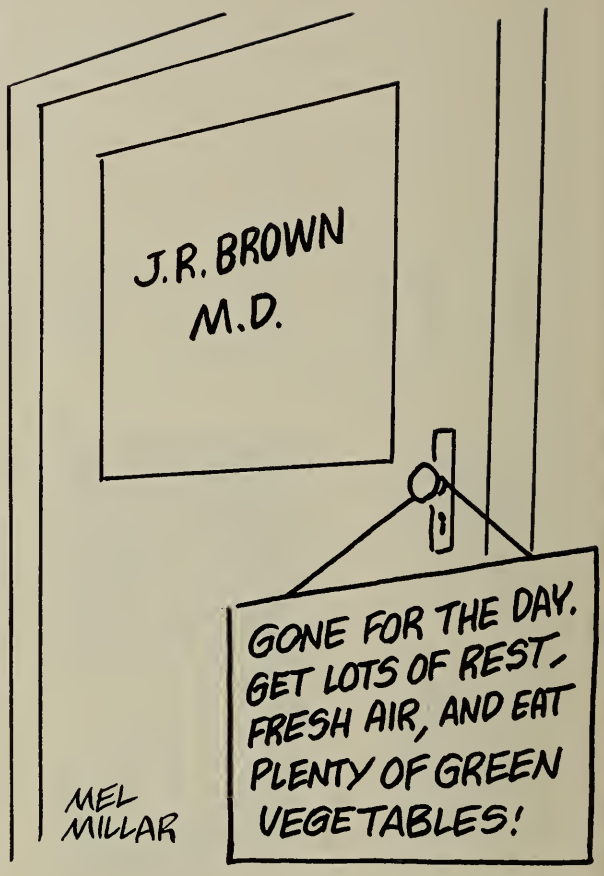


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1. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: *Brit. M. J.* 2:606, Oct. 3, 1959. 2. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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Rotation of the occipito-posterior or transversely arrested head can in most instances be more easily and more physiologically effected with the ventouse than either manually or with forceps. *J. A. Chalmers, M.D., and R.J. Fothergill, M.B. Use of a Vacuum Extractor (Ventouse) in Obstetrics. Brit. M.J. June 4, 1960.*

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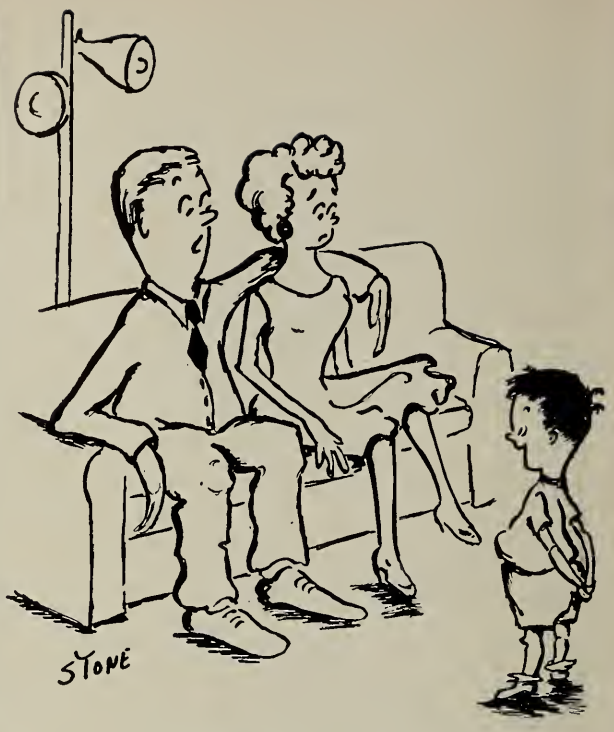
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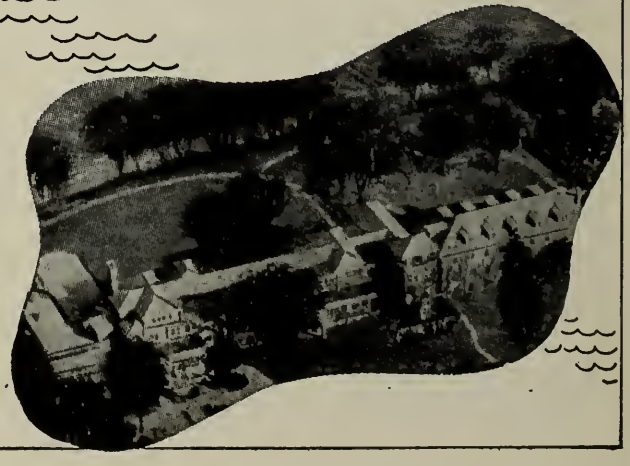
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Cultural factors underlying obesity

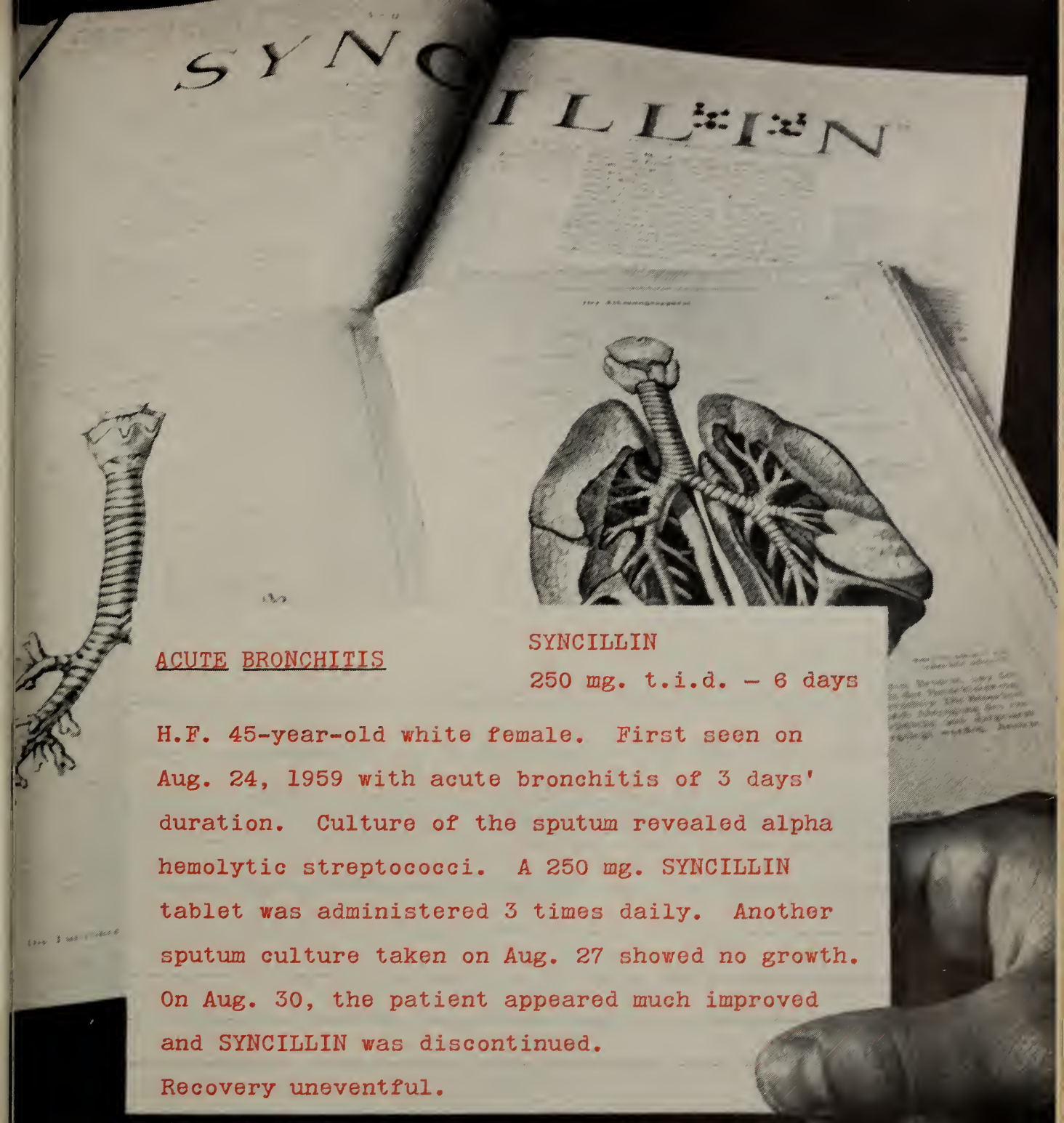
We have a number of other questions concerning possible correlations of cultural and psychological factors with obesity. Is the ability to diet, and to diet consistently, related to belief in a measure of control over one's fate? Is it related to the strength of the belief in science? Is obesity correlated with orientations toward asceticism versus sensory pleasures? Has there been any study of obesity among monks and nuns? Do people who value sensory pleasures in general, such as those derived from perfumes, from physical contacts, from sexual experience, demonstrate an ability to diet more, or less, successfully than others? The degree of emphasis on sensory pleasure may be culturally determined, may vary from one historical period to another in the same culture, and from one class and ethnic group. And within each group there can be variations due to genetic idiosyncratic factors in the life history of individuals. *Hortense Powdermaker, Ph. D. An Anthropological Approach to the Problem of Obesity. Bull. New York Acad. Med. May 1960.*

Diarrhea after gastrectomy

Diarrhea was attributed to the gastrectomy in 27 patients (6.9 per cent). It varied in intensity from an occasional bout of one to three watery stools a day to severe, disabling diarrhea in a few instances; the latter usually cleared up or became mild within the first six months. Of the 27 cases, six had diarrhea for less than six months; in seven it persisted for from one to four years (followed for from three to ten years) before it ceased. Fourteen patients (3 per cent of the entire series) had recurrent episodes of diarrhea for the duration of the follow-up (up to eleven years). In the group of 13 who cleared, 7 had had gastrectomy alone. Of the 14 who persisted, 13 had had gastrectomy plus vagotomy. *Edmund N. Goodman, M.D. The Postgastrectomy Patient. New York J. Med. June 1, 1960.*

The toughest thing about success is that you've got to keep on being a success. Talent is only a starting point in business. You've got to keep working that talent.—Irving Berlin





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H.F. 45-year-old white female. First seen on Aug. 24, 1959 with acute bronchitis of 3 days' duration. Culture of the sputum revealed alpha hemolytic streptococci. A 250 mg. SYNCILLIN tablet was administered 3 times daily. Another sputum culture taken on Aug. 27 showed no growth. On Aug. 30, the patient appeared much improved and SYNCILLIN was discontinued.
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Worrying into obesity

Many persons who become obese react to worry and nervous tension by increasing food intake. Less commonly, obesity develops rapidly in association with specific psychological trauma. Hamburger has suggested four categories which are indicative of the severity of a patient's psychic and emotional difficulties: (1) overeating in response to nonspecific emotional tensions; (2) overeating as a substitute gratification in intolerable life situations; (3) overeating as a symptom of underlying emotional illness, especially depression and hysteria; and (4) overeating as an addiction to food. In the most severe categories, psychiatric therapy must accompany a weight reduction program. *Grace A. Goldsmith, M.D. Management of Obesity. Texas J. Med. Oct. 1959.*

One realizes the full importance of time only when there is little of it left. Every man's greatest capital asset is his unexpired years of productive life.

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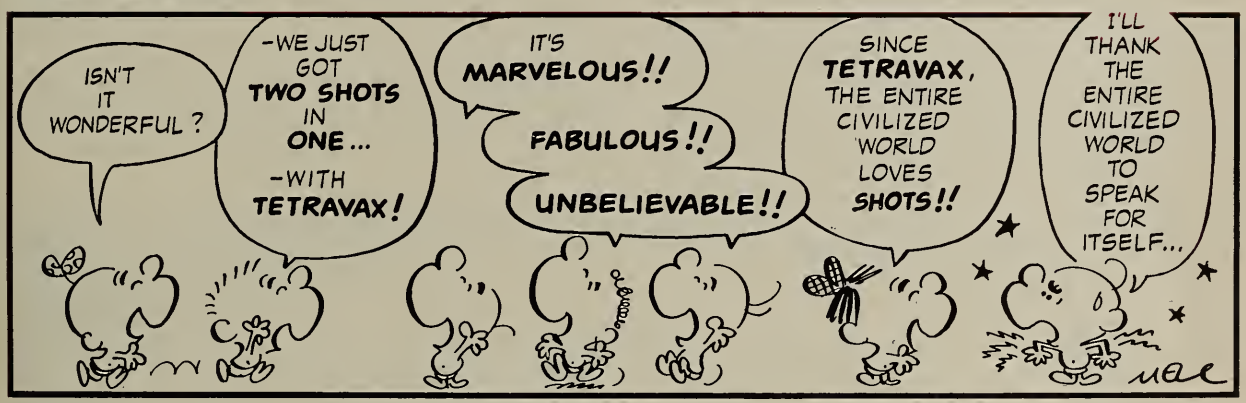
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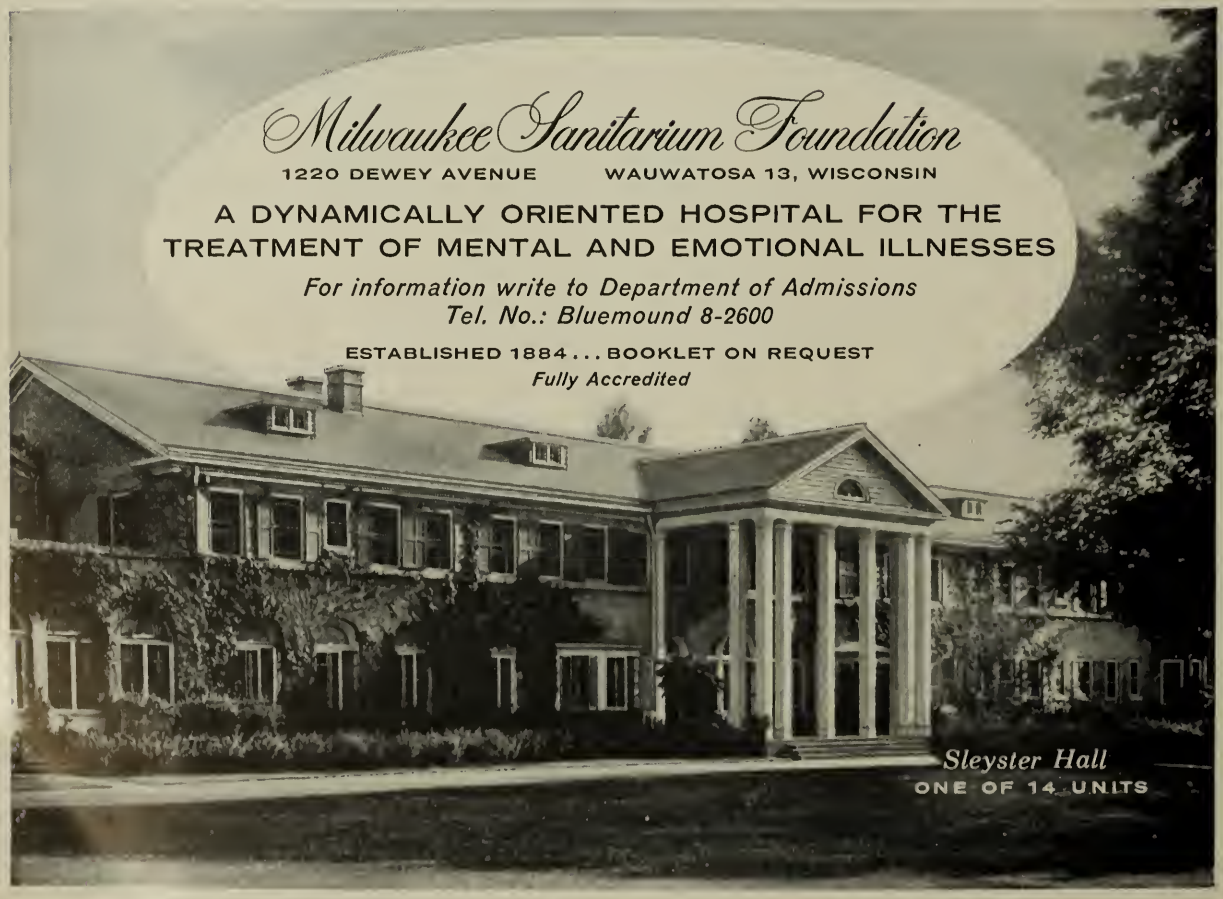
Every nation must determine the precise relation of medical practice to society. The medical profession in my country does not wish to wreck the National Health Service. On the contrary, it is only keen, hard, energetic labor by the vast majority of practitioners that has made the service work and has improved it, but there is still much to do. It acknowledges that some public organization of medical service in my country is necessary, but it wishes decisions on organization to be removed from the realm of politics. For every nation there is the problem of what to do for the portion of the population that cannot afford to pay for full medical care. I feel there must be some form of insurance, voluntary or compulsory, perhaps with some form of state aid or partnership, but I feel that those who can afford to look after themselves should be encouraged to do so. I strongly advise that however much the ordinary citizen is helped financially for medical care he should be asked to make some payment for the services he receives. The big problem is to remove the fear of many that a serious illness or operation will be crippling financially.

I warn you of the greatest danger of all: the bureaucratic machine, which by the turning of the screw can do more damage to doctors and to the general welfare of the patients than anything else. Fortunately, in Britain the profession is not completely nationalized but a large proportion of it is, and there seems to be a continual struggle between our profession and the bureaucracy. A sound health service should be based on freedom for the patient and the profession.

I think if Abraham Lincoln were here today he might have used words similar to those he used at Gettysburg:

> It is for us to be dedicated to the great task before us, that we here highly resolve that these professions under God shall have a new birth of freedom, and that freedom of medical care and treatment of the people, by the people, for the people, shall not perish from the earth.

A. Lawrence Abel, M.S. F.R.C.S. Medicine and the Social Revolution in Great Britain. New York J. Med. June 1, 1960.



as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrachloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gardon, P. E. (50 patients): Deprol in the treatment af depressian. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial af a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Woad, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrachloride cambination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

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Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. **Write** for literature and samples.

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And finally, we believe that in the treatment of atherosclerosis, our objectives should be directed toward improvement in fat tolerance rather than the reduction of any specific lipid fraction of the blood *per se*. Radioactive fat tolerance tests offer an ideal way, therefore, of evaluating the efficacy of any such agent. *Donald Berkowitz, et al. Radioactive Fat Tolerance Studies in Coronary Artery Disease. South. M.J. April* 1960.



Whom shall I forget to say called?



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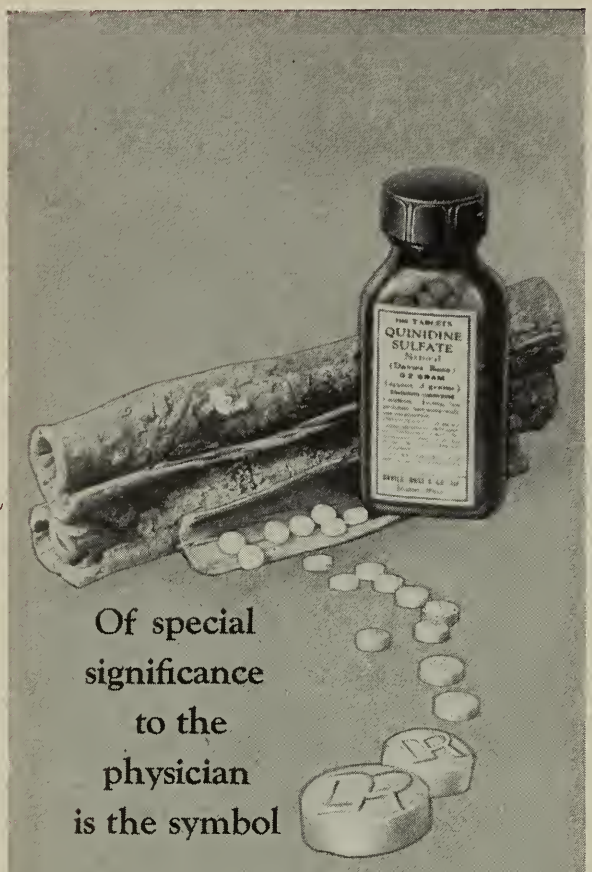
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Incidence of leukemia not on increase in Cornwall

There is no evidence here to show that the incidence of leukaemia has increased during the past 12 years in Cornwall, but there may be some evidence that it is becoming less frequent in the very young. This is in accordance with the opinion of Gilliam and Walker (1958), who said that "presently evident trends in death rates from leukaemia offer no support for a theory that leukaemogenic factors in the American environment have increased sharply within the last 15 years." The disease is now more often diagnosed among the aged, and the mean age at onset shows a steady rise during the period 1948-59. It is argued that this is due to an increasing awareness of acute leukaemia as a disease of old people. Better facilities for diagnosis have resulted in the more frequent discovery of acute leukaemia at all ages over 50, and these facilities first became operative about 1948.

Poverty seemed to have no part in the aetiology of the disease. Saxton *et al.* (1944) showed that underfeeding of mice reduced the incidence of spontaneous leukaemia from 65 per cent to 10 per cent, and Engelbreth-Holm (1954) says that the restriction of calorie intake reduces the incidence of other spontaneous tumours besides leukaemia. The appearance of leukaemia in the well nourished in Cornwall seems to support the experimental evidence.

There is no significant evidence here that x-ray films taken during pregnancy have been associated with leukaemias developing in children. Nor is there any evidence that high local levels of radioactivity associated with granite outcrops in Cornwall have any influence on the disease. *Eileen E. Wood, M.R.C.S. A Survey of Leukaemia in Cornwall,* 1948-1959. *Brit. M. J. June* 11, 1960.

All true educators since the time of Socrates and Plato have agreed that the primary object of education is the attainment of inner harmony, or, to put it into more up-to-date language, the integration of the personality. Without such an integration learning is no more than a collection of scraps, and the accumulation of knowledge becomes a danger to mental health.

— *Sir Alfred Zimmern*



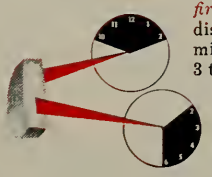
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Chromosomes and disease

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Abstract of Council Actions

Meeting of October 9, 1960

BETTER ENFORCEMENT OF MEDICAL PRACTICE ACT PROMISED

The Committee on Medical Service reported that Judge Vera Binks, Director of Registration and Education, promised to go before the next Legislature to ask for an appropriation for better enforcement of the Medical Practice Act. This is in accordance with the program suggested when the physicians of Illinois backed legislation to raise the necessary funds through biennial registrations. The Committee was instructed to confer with the director on the spending of the funds and the establishment of standards for employees to do the work.

COMMITTEE TO AID IMPLEMENTATION OF MEDICAL AID TO AGED

Mr. Walter L. Oblinger, General Counsel, reported that the next session of the Legislature will see the introduction of bills to implement the recently passed federal act to provide medical care for the needy and near-needy aged. The Illinois Public Aid Commission has requested suggestions along this line. This matter was delegated to a special committee composed of the chairmen of the Aging, Medical Service, and Public Relations committees and the Advisory Committee to the IPAC, using the existing IPAC Advisory Committee where necessary. Dr. Cannady has been appointed chairman of this special committee.

DISTRICT COUNCILOR MEETINGS ARE PRAISED

Praise was expressed for the district councilor meetings already held. Commendations came from officers who had been the main speakers. Dr. H. Close Hesseltine, President, said that these meetings are extremely important in informing the membership of the services available under the reorganization. Satisfaction also was expressed by Dr. Edwin S. Hamilton, President-Elect; Dr. Andrew J. Brislen, First Vice President; and Dr. Clinton D. Swickard, Second Vice President.

Mr. Robert L. Richards, Executive Administrator, pointed out that the Council was interested in having representatives from all medical societies but not so many as to prevent talks on an intimate basis. This has been accomplished, Mr. Richards reported.

Meetings have already been held in the 4th District at Peoria; 10th District at Steeleville; 8th District at Mattoon; 2nd District at LaSalle, and 1st District at Rockford. Two more are scheduled for this Fall: 11th District at Joliet on October 30 and the 6th District at Jacksonville on November 13. The remaining districts will be covered after the first of the year.

PHYSICIANS ON LIST FOR WHITE HOUSE CONFERENCE DELEGATES

Dr. Edward W. Cannady, Chairman of the Committee on Aging, reported that a suggested list of Illinois delegates to the White House Conference in January, was presented to the governor. It includes 15 physicians.

CALLS FOR DEFENSE OF HIGH MEDICAL STANDARDS IN U. S.

Dr. Edward A. Piszczek, Chairman of the Council, who recently returned from a month in Europe, reported that German physicians operating under the governmental medical system were grossly underpaid and handicapped in the dispensing of medical service. Dr. Piszczek stressed the need for physicians in the United States to aggressively fight for the maintenance of the high standards in this country.

RETIRED MEMBER ELECTED

Dr. Bert Roan, Macomb, was elected to retired status.

COMMITTEE CHANGES ANNOUNCED

In a series of actions involving committee members, the Council accepted three resignations, named a new chairman, and added several new members to existing committees. Actions were:

1. Appointed Dr. Carl E. Clark as Chairman of the Committee on Radiation to succeed Dr. Roger Harvey, who has resigned.
2. Accepted the resignation of Dr. Richard J. Bennett from the Committee on Impartial Medical Testimony. No replacement is planned.
3. Deferred to Dr. Samuel A. Levinson, Chairman of the Committee on Impartial Medical Testimony, and to the Committee, the selection of a successor to Dr. LeRoy Sloan, who resigned as consultant to the Committee.
4. Dr. J. O. Firth was named to the Committee on Nursing.
5. Dr. George E. Kirby was added to the Committee on Postgraduate Medical Education and Scientific Service.
6. Dr. John C. Smith was approved to replace Dr. Allison L. Burdick on the Committee on Medical Economics.
7. Drs. Roland R. Cross and Carl Clark appointed members of the Interprofessional Council.

MISCELLANEOUS ACTIONS

A request from the Illinois Hospital Association for joint sponsorship of a Health Careers Council has been referred to the Committee on Public Relations and Nursing Committee for joint study.

A request from the Illinois State Bar Association for the development of a medical-legal code, similar to that adopted by the Chicago Medical Society and Chicago Bar Association, has been referred to the Liaison Committee to the Illinois Bar Association.

A recommendation for the establishment of a Section on Nervous and Mental Diseases has been referred to the Annual Meeting Committee.

Dr. Eugene McEnery, Chicago, was designated to represent the ISMS at an AMA conference on athletic injuries, to be held in Washington preceding the AMA interim meeting.

Mr. Robert L. Richards, Executive Administrator, or his designee, was named to serve as one of the two ex-officio members of the Illinois Joint Council to Improve the Health Care of the Aged. Mr. Richards, because of his past activity in the American Public Health Association, also was named to represent the ISMS at the forthcoming APHA annual meeting in San Francisco.

It was decided to give the approval of the ISMS if the Illinois Nurses Association should apply for membership in the Illinois Joint Council to Improve the Health Care of the Aged.

The providing of radio programs and the supplying of speakers for lay groups was transferred from the Committee on Postgraduate Medical Education to the Public Relations Committee.

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Vol. 118, No. 4 **October, 1960**

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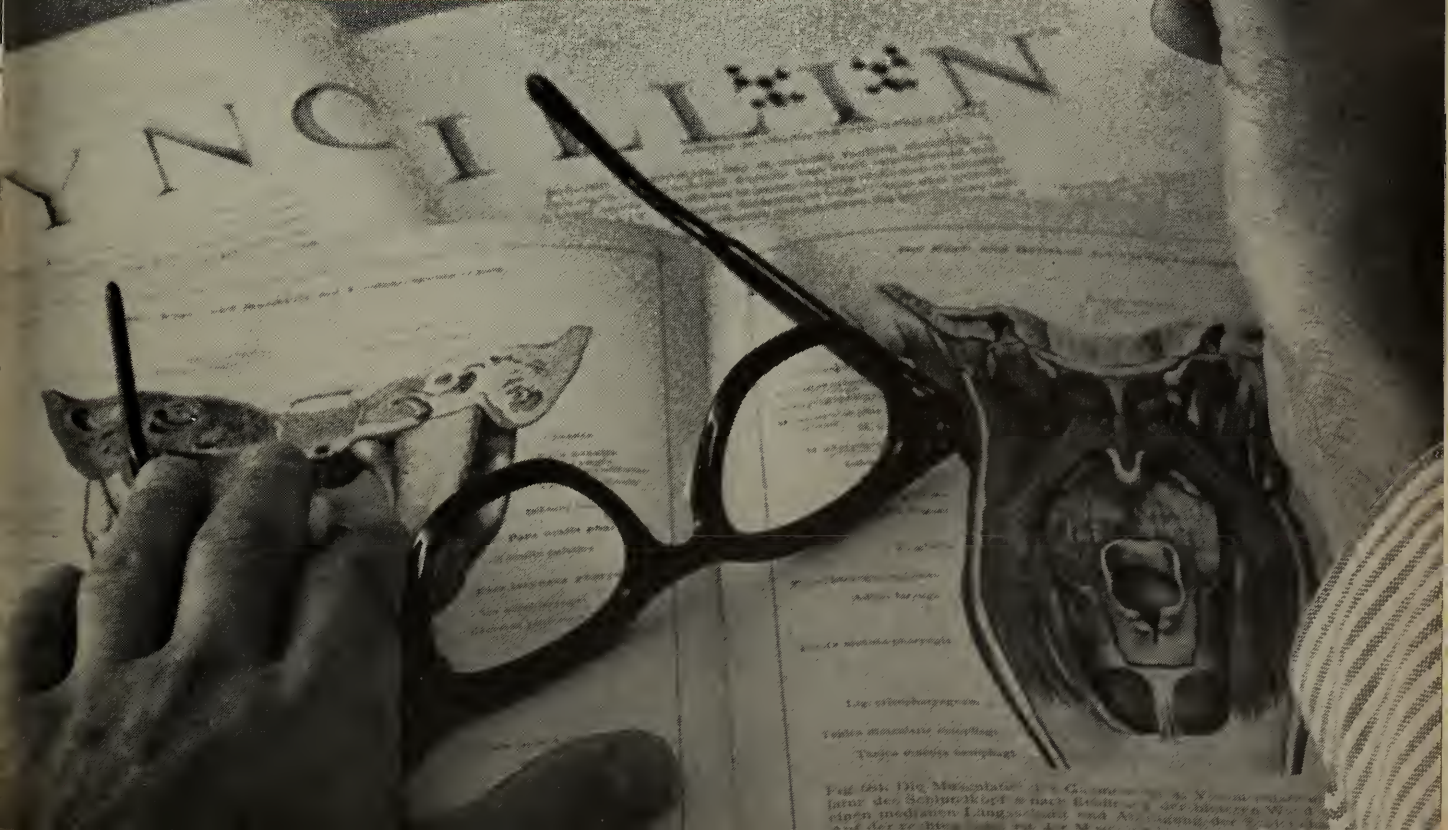
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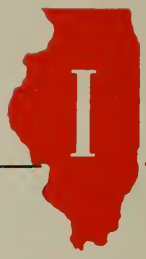
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W. M. 24-year-old-male. Admitted with sore throat which had progressed rapidly in severity for 24 hrs. Temp. 104.4. Pulse 110. Acute pharyngitis and enlarged, red, bulging tonsils covered with pus. Throat culture revealed beta hemolytic strep. Patient given 500 mg. SYNCILLIN t.i.d. Within 24 hrs., fever terminated by crisis with marked relief of local signs and symptoms. After 5 days, infection was cured.

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The Month in Washington



The federal government is offering states liberal matching funds to provide health care for needy and near-needy persons 65 years of age and older. The program, which Congress approved in the bob-tailed post-convention session, is supported by the American Medical Association and allied health groups.

Congressional approval of the federal-state program marked a victory for the medical profession and a defeat for Democratic Presidential Nominee John F. Kennedy, the AFL-CIO, and other advocates of the social security approach to the problem. In a key vote on the issue the Senate rejected by a 51-44 vote a Kennedy proposal that would have provided hospitalization and medical care for the aged under the social security system. The Kennedy plan would have required an increase in payroll taxes.

Republicans and Southern Democrats joined in the Senate to defeat the social security approach which was opposed vigorously by the medical profession.

After voting down the Kennedy plan and a separate proposal of the Eisenhower Administration, the Senate passed a modified version of a House-approved program. The modifications, sponsored by Sen. Robert S. Kerr (D., Okla.) and others, provided for increases in the percentage of federal matching funds and for administrative changes designed to facilitate state participation.

Under the legislation as signed into law by President Eisenhower, (1) substantial increases are authorized in federal grants to states to help with health care expenses of the 2.4 million persons on old age assistance rolls, and (2) Federal matching funds are offered the states to finance a new program of health care for an estimated 10 million aged persons who are not on relief but whose incomes may be inadequate to take care of all their health costs. Start of the program was authorized for October 1 for those states where new state legislation is not required.

Administration of the program rests entirely with the states, subject to Federal approval in broad terms, and each individual state decides whether or not it participates. Eligibility standards for beneficiaries and what health care services are provided are matters for the state to decide. If a state so chooses, it can take care of all the health needs of an eligible beneficiary. The law authorized in patient hospital services; skilled nursing home services; physicians' services; outpatient or clinic services; home care services; private duty nursing services; physical therapy and related services; dental services; laboratory and x-ray services; prescribed drugs, eyeglasses, dentures, and prosthetic devices; diagnostic screening and preventive services, and any other medical care or remedial care recognized under state law.

For medical expenses of persons on old age assistance rolls, the Federal government will contribute 50 to 80 per cent — with states with low per capita income getting the larger per-

(*Continued on page 22*)

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WASHINGTON (Continued)

centages of Federal aid — of an amount equal to $12 multiplied by the number of old age assistance recipients in a particular state.

The matching formula will be the same for financing the health care of the near-needy, but there is no $12 limitation figure.

Health, Education and Welfare officials estimated first-year costs of the program at $262 million — $202 million Federal and $60 million state. Annual costs are estimated to rise by the end of the fifth year to $340 million Federal and $180 million state. However, these estimates admittedly are no more than educated guesstimates because so much depends upon state action.

It was estimated that maximum participation and a state contribution of $5.9 million would bring Illinois $9.8 million in Federal matching funds in the first year of the program.

The medical-care-for-the-aged legislation was included in an omnibus measure titled Social Security Amendments of 1960. It also eliminated the age 50 requirement for eligibility for disability insurance benefits.

The Senate knocked out of the House bill a provision that would have brought physicians under social security coverage.

On other legislation of interest to the medical profession:

Congress passed bills authorizing expenditure of $10 million of counterpart funds abroad to stimulate international research; authorizing up to 15 per cent of National Institutes of Health research grants for non-governmental medical research; directing a broad study of air pollution problems; requiring informative labeling on packages of hazardous substances for household use, and giving the government power to establish a tolerance on the amount of color additives that may be used in various products.

The Senate failed to act upon House-approved legislation that would have given physicians and other self-employed persons a tax break on income put into private pension plans.

Governments, like clocks, go from the motion men give them, and as governments are made and moved by men, so by them they are ruined also. Therefore governments depend upon men rather than men upon governments.—William Penn

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Spasm related to trauma	15	6	1	—	22
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The 1959 discoveries about mongolism

Early in 1959, a group of French investigators published their discovery that three mongoloids whom they had studied had 47 chromosomes instead of the 46, which is standard for human beings. Chromosomes are the microscopic life-threads within each cell which carry the still smaller "genes" of heredity, such as eye color and height. Later that year British scientists reported the same extra chromosome in each of half a dozen mongoloids.

The cautious London medical magazine, *Lancet*, called these discoveries "the first fruits of a technical advance which may revolutionize human genetics." This technical advance in examining bits of tissue includes stopping chromosomes as they divide, treating them so that they swell, and making greatly enlarged photographs of these microscopic carriers of heredity. Only recently have scientists had a clear vision of chromosomes, and followed them with the light microscope through all their changes as magnified as much as 2,000 times.



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The significance of the 47 chromosomes in mongoloids challenges the scientists. In their 1959 reports, the British scientists wrote, "The primary disorder may lie in oögenesis"—formation of the egg before fertilization. Their theory means that the whole sad picture of mongolism could lie in an irregular egg before it is fertilized. *Mongolism: Hope through Research. U.S. Public Health Service Publication No. 720.*

Urinary infection in children

The most common urinary problem in children is urinary infection, which may be primary or secondary to a focus of infection or an obstructive lesion. Most cases are secondary. Complete urologic studies are indicated after the first attack of infection in males and the second in females. Obstructive lesions of the urinary tract in children must be removed promptly because decompensation takes place more rapidly than in adults. *E. Burns, M.D., and R. F. Carter, M.D. Urologic Problems in Children. J. Arkansas M. Soc. May 1960.*

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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*In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

Complete bibliography available on request.

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Medical students in India

The caste system [in India] has found its place in medicine as well. In most medical schools a certain number of seats are rserved for the lower eastes. There are also geographie eriteria of selection. The eandidate from a erowded eity may encounter considerable diffieulty in gaining admission, whereas the student from a remote area has a distinet advantage. In some schools one ean still buy his entranee for a set price, although this system is losing favor. Almost the only school that seleets its students on purely aeademie and eharaeter eriteria is the All-India Institute of Medieal Seienee in Delhi, a eenter still being built, which will serve as a model for other schools and train graduate and undergraduate leaders in medicine for the entire nation. One other difference between the student seleetion in India and in the United States is the percentage of female students. Many Indian schools have an allotted quota of seats for women, and frequently there are more women than men. *Kevin M. Cahill. A Medical Student's Impressions of India. New York J. Med. April* 15, 1960.

Mumps vaccine

An inactivated mumps virus vaccine produeed in embryonated hen eggs, when given in two subeutaneous doses at intervals of one to four weeks, eaused antibody responses in practically all suseeptible individuals. Booster injeetions were required every 6 to 12 months thereafter to maintain the proteetion. In fact, such spacing of injections after the initial series of two injeetions seemed to give the most satisfaetory responses with higher neutralizing antibody titers than those seen after primary vaeination.

There are no clear indications for the use of mumps vaccine except perhaps in exposed susceptible adult males. Inapparent mumps infeetions are common in children, and many presumed susceptible adults may be shown to have immunity if skin-tested. In sueh instances use of the vaeeine is avoided. This vaccine should not be used in persons known to be sensitive to egg protein. *George M. Owen, M.D. Prophylaxis of Viral Infections. M. Ann. District of Columbia. April 1960.*

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Communication Barriers of the Older Person

Atwood Hudson, Ph.D., *Rockford*

Many evidences appear showing that the citizens of Illinois are becoming increasingly cognizant of the pressing need for planning for the rising number of the aged. The demonstration and research program currently in progress under the auspices of the Illinois Public Aid Commission, the "Rockford Plan" for extending Blue Cross and Blue Shield services, and the Conference on Aging held in Springfield in September, 1959, are only a few specific indications of the growing awareness of the needs of the senior citizens of Illinois. The matter is urgent because, by 1965, it is estimated that one person in every 10 in Illinois will have reached age 65. Furthermore, the present life expectancy of men at age 65 is approximately 13 years while women of that age are expected to survive for 15½ additional years.

There has been apparent concern for providing medical care for the aged, for appropriate housing, recreation facilities, and part-time employment. But little attention has been given to the communication barriers of the elderly. The ability to understand and be understood is a primary human need. If the physician is to administer to health needs of the older person successfully, if the nurse in the geriatric ward is to manage him effectively, if the family is to play its proper role in making him feel needed in the home, if the nursing home personnel is to help him make an adjustment, he must be able to speak intelligibly and to understand what is said to him.

What are the communication problems among the aged? Loss of hearing probably is the most prevalent. As long ago as 1940, the National Health Survey reported that in the age group 65-74, 73 men and 54 women in every 1,000 had an average hearing loss of 47 decibels or more for the critical frequencies, 1,024 and 2,048 cycles. With improvement of equipment and in testing techniques developed within the intervening 20 years, the incidence doubtless is greater than these figures indicate. A more recent study demonstrated that the aged often have difficulty in discrimination for speech, even though the threshold responses to the puretone audiometer may show only a mild loss.

Director of the Rockford College Speech Clinic

Although there is a dearth of statistical information on incidence, the loss of language due to cerebral vascular accident is prevalent among the aged. A third increasingly frequent communication problem results from surgical removal of the larynx. The American Cancer Society, which is currently conducting a survey to determine the number of laryngectomees living in the United States, estimates they total between 12,000 and 15,000. Approximately 4,400 new cases of cancer of the larynx are reported each year, and this figure is said to be increasing by four per cent. Men outnumber women ten to one. The average age of laryngectomees is between 55 and 60. Because the survival rate is high, many are in the 65-and-over age group. In addition to the above, there are problems of voice and articulation resulting from such serious neuropathologies as parkinsonism, multiple sclerosis, and chronic bulbar palsy.

Remedies for defects

What are the possibilities of rehabilitation for the aged who may have a handicapping hearing loss, language deficits, loss of voice, dysarthria, or a combination of defects? Just as Dr. Howard Rusk has urged physicians to get their hemiplegics out of the back beds of the medical wards and out of the back bedrooms of homes and to teach them ambulation and self-care, so the speech pathologist urges a dynamic approach to speech and language rehabilitation. Included in the plan are speech and language therapy, lip reading, and fitting of hearing aids, followed by a program of auditory training. Dr. Rusk and his associates reported at the conclusion of a four year study that, "despite the handicaps of age, disease, and relatively long duration of symptoms, services should be extended to a larger number of aphasic patients."

Dr. Margaret Lefevre, consultant in speech and hearing of the Highland View Hospital in Cleveland, on the basis of her experience, says, "Speech therapy may benefit patients at an age when they once would have been considered too old. It has been determined that age per se is not a primary determining factor." The clinical experience of the writer at the Rockford College Speech Clinic corroborates these reports.

Hearing conservation programs conducted in nursing homes have revealed that periodic otological and audiological evaluations are highly desirable. One report stated that the hearing of some of the aged was improved by so simple a service as the removal of impacted cerumen. Instruction in lip reading was helpful to many. A most significant finding was that the aged have to be prepared physically and psychologically for acceptance of a hearing aid; they also need a program of auditory training in learning to use them.

A rather impressive record of success in teaching esophageal voice to laryngectomees has been reported although the individuals were not necessarily in the 65 and over age group. William Waldrop, for example, stated that approximately 90 per cent of patients referred to St. Luke's Hospital Clinic, Chicago, over a two year period learned acceptable esophageal speech. Other training centers have been set up. The Illinois Medical Journal for December, 1959, lists six speech clinics in Chicago and eight others throughout Illinois where voice training for laryngectomees is available.*

With individuals suffering from such neuropathologies as parkinsonism or multiple sclerosis, the prognosis is guarded for the acquisition of normal patterns of articulation and normal voice quality, although rate of speaking and phrasing may be improved. The speech specialist often serves these patients most effectively simply by encouraging them to continue to speak. Even though the patient's speech is "different," he still is able to make himself understood. Regardless of the type of speech, language, or hearing problem the geriatric patient may present, the role of the specialist in communication may be one of direct service in evaluation and administration of therapy for improvement; or indirect service in an attempt to modify the patient's environment to better meet his needs.

The greatest present need, so far as communication problems are concerned, is realization on the part of physicians — especially those in general practice and in internal medicine who see the greatest number of geriatric patients — that not only can the aged patient profit from instruction but as a result of it he will be more easily managed by all concerned with his care.

*Two clubs for laryngectomees, one in Rockford and the New Voice Club of Central Illinois, may be reached by addressing the American Cancer Information Centers at either 206 Main St., Rockford, or 310 W. Church St., Champaign.

Obviously, an elderly person with loss of hearing or language and articulation problems, often complicated by hemiplegia or other disabilities, requires a multidisciplinary approach to treatment such as can be provided best by comprehensive rehabilitation centers. There has been a notable growth of these facilities within the past few years. Some are connected with medical schools, some with hospitals for sustaining care, others are independent community programs.

Communities large enough to support such centers need the leadership of the medical profession in their organization. Even in smaller communities there are many specialists, including those in speech and hearing, whose active assistance could be secured in comprehensive efforts to meet the needs of the aged. So varied are the needs of the senior citizens that the problem calls for inspired leadership and for the utilization of all available resources. Illinois soon may provide for its geriatric population such excellent service as that provided for its pediatric population by the Division of Services for Crippled Children.

REFERENCES

Illinois M.J.: Reference Sheet No. 2, 116:322-323, 1959.

Beasley, W. C.: Characteristics and Distribution of Impaired Hearing in the Population of the United States, J. Acoustic Soc. of America 12:114-121, 1940.

Pestalozza, G., and Shore, I.: Clinical Evaluation of Presbycusis on the Basis of Different Tests of Auditory Function, Laryngoscope 65:1136-1163, 1955.

Ranney, J. L.: Executive Secretary of the International Association of Laryngectomees, personal communication.

Marks, M.; Taylor, M., and Rusk, H.: Rehabilitation of the Aphasic Patient, Neurology 7:837-843, 1957.

Lefevre, M.: Speech Therapy for the Geriatric Patient, Geriatrics 12:691-695, 1957.

Grossman, B.: Hard of Hearing Persons in a Home for the Aged, Hearing News 23:11-20, 1955.

Heffler, A. J., and Rosenthal, M.: Montefiore Home of Cleveland Heights, Ohio, annual report, 1958-9.

Waldrop, W.: Personal communication.

Wounds and disease in Confederate Army

Confederate forces actively engaged in the four year's War Between the States numbered no more than 600,000 troops. This small force faced a total number of 2,800,000 soldiers mustered as volunteers and through the world's first military draft into the Union Army, or approximately four times the fighting contingent of the Confederate States. Of the 600,000 Confederate troops, 54,000 were killed outright and approximately 200,000 died either from battle wounds or from disease. Another 200,000 were lost to the Confederate States Army as prisoners of war because of the policy of non-exchange of prisoners adopted and enforced by the United States. Another 100,000 were discharged because of disability from wounds or disease or actually deserted during the war years. Within this small and horribly decimated force, approximately 3,000,000 cases of wounds and disease were cared for by the Medical Corps of the Confederate States Army. On an average, then, each Confederate soldier was disabled by wounds and sickness about six times during the war. On April 9, 1865, as the war ended at Appomattox, General Lee could not muster 10,000 men who were fit for active warfare from his former great Army of Northern Virginia; Dick Ewell surrendered at Sailor's Creek with only 8,000 men to Phil Sheridan. *R. B. Stark, M.D. Surgeons and Surgical Care of the Confederate States Army. Virginia M. Month. May* 1960.

Anatomic and Physiologic Basis For Burn Therapy

William Schumer, M.D., *Chicago*

In the past ten years, the treatment of burns has undergone changes as radical as the homeostatic changes that occur in the human organism as a result of the burn itself. Study of pathologic anatomy, physiology, and care of the wound has increased the salvage rate of the severely burned. It is the purpose of this paper to correlate the newer concepts of burn therapy so that they are better understood.

Pathologic anatomy

First degree burns involve only the superficial epidermal layer — the stratum corneum. An example of a first degree burn is the common sunburn.

The second degree burn involves the strata corneum, lucidum, and granulosum. The only layer it does not involve is the stratum germinativum. It is characterized by blisters or bullae of the skin due to an exudation of fluid into the irritated epidermis. Because the stratum germinativum is not involved, regeneration of the epidermis will occur uneventfully, usually in one to two weeks. If, however, superimposed infection destroys the stratum germinativum remnants, then the lesion is converted into a third degree burn. Epithelization of these deep second degree burns requires 25 to 35 days.

The third degree or full thickness burn is characterized by complete destruction of the epidermis down to dermal fat. Coagulation necrosis of the fat and thromboses of the subpapillary plexi and other small vessels of the underlying tissues occur. Increased capillary permeability with the subsequent formation of interstitial edema is greater than in second degree burns. In 7 to 10 days the dead skin liquefies partially by leukocytic digestion, and suppuration takes place. This type of burn also destroys the capillaries of muscle with subsequently increased destruction of red blood cells.[1]

In my experience, it is quite difficult, if not impossible, always to distinguish between second and third degree burns on first sight or at the first dressing. Usually at redressing, the depth and extent is less severe than anticipated. Distinction may be made by the pin prick test. This test is based on the principle that in full thickness injuries the nerve corpuscles are destroyed resulting in diminished pain sensitivity, while in partial thickness burns the area may be hyper-anesthetic due to irritation of nerve endings.[1]

Pathologic physiology

The four phases of burn pathology are (1) burn edema, (2) wound complications, (3) wound closure (beginning anabolism), and (4) maturation of new skin, and rehabilitation. The symptoms produced depend upon the extent and depth of the burn. A first degree burn of less than 30 per cent of the body will not produce the alterations to be discussed. However, full thickness burns of 20 per cent and over will produce profound symptoms. Therefore, in discussing the above phases of burn physiology, reference is made only to the full thickness burns of over 20 per cent of the body and partial thickness burns of over 40 per cent.

The primary pathologic evidence of burns is edema, which starts to develop under the skin within minutes after the burn is sustained. Edema is due to two factors:

1. Destruction of ability of the arterioles to constrict, and

2. The injury to the capillary wall which increases its permeability and produces transudation of fluid into the extracellular space. This transudate is similar to plasma and contains a high protein component (3 to 5 Gm. per 100 cc.). It also has a high content of sodium, chloride, potassium, and bicarbonate.

The magnitude of fluid loss in a severe burn can be tremendous. Considering that a patient with a burn of the anterior trunk and abdomen may accumulate as much as eight liters of fluid in this area without much change in contour or shape, we begin to understand the changes that burn edema can have on the hemodynamics of the patient.

As a result of the loss of fluid and electrolytes from the total volume of circulating body fluids, the kidney shuts down in an attempt to conserve water, action prompted by the stress reaction of pituitary outpouring of antidiuretic hormone. There will be a maximal tubular reabsorption of sodium, chloride, and bicarbonate and increased excretion of potassium and nitrogen. Because there is a decreased renal blood flow, an acute renal insufficiency develops. This is the usual cause of death in the first six to seven days after injury. Let us assume that with adequate measures the patient can get over the initial circulatory shock. He continues to pour his body fluids into the burn area for two to four days. There is no known way to stop this outpouring of fluid; the only way to save the patient is to replace what is lost into the wound.

Finally, the end of the transudation phase comes, and there is a sudden reabsorption of fluid from the wound as the patient goes into the diuretic phase of burn edema, apparently as a result of fluid therapy. One must repair the osmotic losses (albumin) and restore hydrostatic pressure in the vascular space to a level above the osmotic and hydrostatic pressures in the burn edema. This probably takes two to four days. Urine volume increases over and above the amount of fluid intake. The edema of the wound gradually disappears, and in four to six days the urine volume is normal.

The patient now passes into the second pathophysiologic phase in which the care of the wound and its complications are of uppermost importance. This phase is characterized by a prolonged negative nitrogen balance due to the catbolism of protein for caloric value, and increased exudation of body fluids and solids through the open and septic burn surface, a septic starvation and rapid weight loss, and finally a trend toward anabolism as the wound closes. The degree of starvation, weight loss, and cachexia produced depends on the duration of the phase, the caloric intake, and the extent of the septic process which produces further protein loss. If it is possible to maintain the patient in positive nitrogen balance and protect him against sepsis through antibiotics, then this phase will be shortened. However, in most instances, especially when dealing with over 30 per cent full thickness burns, this is not possible. The patient loses a great deal of weight, and if there is incompetent treatment he is depleted of blood volume and protein stores. Terminally, septicemia with septic shock and a debilitation develops and death ensues.

Such downhill progression is fortunately not usual. Normally, protein intake, wound care, and antisepsis are adequate, and positive nitrogen balance with wound closure occurs. There are fewer temperature elevations and weight stabilizes; this heralds the beginning of the third pathophysiological phase called beginning anabolism.

During the fourth phase maturation of new skin takes place, and further anabolism is characterized by more weight gain. The skin not covered by grafting will fibrose and contract. The patient begins to gain back the 15 to 50 pounds he lost. He will require 3 to 12 months to regain his former skeletal muscle and fat distribution. In this period he must understand his limitations because of the necessity of using his caloric energies for completion of anabolism and repair.

Treatment

Let us consider the treatment of burn in a hypothetical case. A patient 35 years of age is admitted to the emergency room with burns of both lower extremities, anterior and posterior, as well as the abdomen anterior up to the umbilicus and posterior to the first lumbar spine. His genitalia are also involved. The following basic first aid treatments are necessary:

1. Establish an airway. Any difficulty in breathing due to smoke inhalation or rales in the chest due to endobronchiolar inflammation definitely indicate tracheostomy.

2. Insert a catheter in the patient immediately. In a patient with genitalia burns, outpouring of fluid into the interstitial spaces closes the urethra in one-half hour.

3. "Establishing the intravenous life line" by venipuncture or venous cut down is an immediate step in the therapy. At the same time blood may be withdrawn for examination of electrolyte modalities and hematocrit, as well as typing

and cross-matching. At present, a polyethylene tube in the vein seems to give the maximal longevity of use. A unit of plasma or dextran in saline may initiate fluid therapy until a definite plan has been crystallized.

4. Estimate the burn area by using the "rule of nine" (9% each for arms and head, 18 per cent each of legs and trunk surfaces). Record history and physical examination.

5. Give tetanus prophylaxis to a deep burn because of the suitability of the environment for contamination by anaerobes. The usual dosage is 5,000 units of tetanus antitoxin, or 0.5 cc. of tetanus toxoid for those patients who have received it previously.

6. Start antibiotics immediately. They are not given to reduce the wound sepsis, because the vascularity of the burn wound has been destroyed, but they may control bacteremia and septicemia. The dosage of antibiotics varies with different clinicians. Most are using 10 to 20 million units of penicillin along with 2 Gm. streptomycin daily.

With the bottle of plasma or dextran running and the previous steps accomplished, one now maps the wound and plans fluid therapy. This is the crux of the treatment in the burn edema phase. Moore[2] in his study of burns has found that the extracellular fluid volume is capable of expanding 50 per cent, an increase of 10 per cent of body weight. This means the extracellular fluid will have a total volume of 30 per cent of body weight. He noted that in this increase of extracellular fluid, there is at least 100 mEq./L. of sodium, 750 mEq./L. of chloride, 350 Gm. of protein and a daily loss of 70 mEq. of potassium.

The basic budget, therefore, for the first 48 hours consists of giving the patient 10 per cent of his body weight as colloid solution in isotonic electrolyte on a descending scale of infusion. He is given one half of this in the first 12 hours and a quarter in the second 12 hours, then the remainder in the second 24 hours. In addition, he is given 1,000 cc. of 5 per cent glucose in water to cover pulmonary losses and 1,500 cc. of dextrose in saline for losses through urine and skin. The obligatory losses (urine, pulmonary, and skin) are revised according to changing clinical circumstances—upward in high temperatures and weeping wounds, and downward in anuria. To replace the destruction of cells from the burn, add 500 cc. of blood.

Example: Age — 35 Weight — 70 Kg.
Estimated normal extracellular fluid is 20% × 70 = 14 liters
Area of burn is 45%: Anterior & posterior — lower extremities
Anterior & posterior abdomen up to umbilicus and lumbar 1 respectively.
Dry char.

The important aspect of this mapping is to determine the full thickness destruction, for here is where the severe metabolic alterations of burns take place. In his description of types of burns, Moore[2] speaks of an index by which the areas of the third degree burn extent plus one half the second degree burn extent are measured. The higher the index, the higher the metabolic alteration and mortality.

Estimation of the contents of burn edema in this patient for the first 48 hours:

Water	7000 ml.
Sodium	900-1000 mEq.
Chloride	650 mEq.
Bicarbonate	150 mEq.
Protein	325 Gm. (50 Gm. nitrogen)

Cell water mobilization into edema for first 48 to 72 hours:

Water	1000 ml.
Potassium	150 mEq.
Pulmonary water	2000 cc.
Renal water	2000 cc.
Surface water	1000 cc.
250 cc. of blood is lost in hemolysis	
Total	13000 ml. water
Sodium	950 mEq.
Chloride	650 mEq.
Bicarbonate	150 mEq.
Potassium	150 mEq.
Protein	50 Gm. nitrogen

The method of replacement of the colloid would be apportioned as follows:

First 12 hours 3,500 ml. total of colloid consisting of ¾ plasma (2,500 cc.)
¼ dextrose in saline (1,000 cc.)

Second 12 hours 1750 ml. colloid
1400 ml. plasma
350 ml. dextrose in saline

Second 24 hours 1750 ml. colloid
1400 ml. plasma
350 ml. dextrose in saline

The 5,000 cc. for obligatory losses is divided into 3,000 cc. of 5 per cent glucose in saline and 2,000 cc. of 5 per cent glucose in water. Fluids are divided equally in the 48 hour period.

TABLE 1.—Progress and Rate of Infusion in Burn Therapy.

Time	Blood Pressure	Pulse	Respiration	Urine Sp. Gr.	Hematocrit	Urinary Output
9:00	70/0	140	40/min.	1.030	60	15 cc.
10:00	90/60	120	30/min.	1.020	50	20 cc.
11:00	100/80	100	20/min.	1.015	45	30 cc.
12:00	110/80	90	18/min.	1.010	40	50 cc.
36-48 hours later	120/80	80	15/min.	1.006	35	120 cc.

How can we be sure that the fluids are satisfying the losses? There are clinical appearances, the hematocrit, hourly urine output, urinary specific gravity, blood pressure, pulse and body weight. After the fluids have been calculated, house officers and nurses can maintain a chart at the burn patient's bedside. Table 1 shows approximately how one can determine the progress and rate of infusion. When the specific gravity, hematocrit, and pulse remain high, and the blood pressure and urinary output remain low, the indication for faster rate of infusion is present. When the urinary output approaches 50-75 cc., the hematocrit 40-50, the pulse 90-100, and the specific gravity 1.015-1.020, and when the blood pressure is normal, then the fluid intake is adequate.

The important factor in this therapy is the ability to determine the diuretic phase. When the urinary output approaches 100-200 cc. and the hematocrit and specific gravity drop, then one can be certain that diuresis is taking place; the fluid must be diminished accordingly. The weight, if feasible, should be recorded twice daily. There should not be more than an 8 to 10 per cent gain. If the patient gains more, he is being overloaded with fluid; if he is losing weight, this would indicate diuresis. The evaluation of weight gain and loss and hematocrit estimation are the only methods that can be used to estimate fluid status when there is an acute renal insufficiency.

Wound care during the period of burn edema is simple. However, controversy exists. Some authors feel that nothing should be done to the wound in the way of cleansing, while others still cleanse the wound with cotton pledgets and bland white soap. The question of open or closed treatment of the wound is still controversial. One is impressed with the fact that there is very little difference in result whether the wound is washed or not and whether the wound is left open or not. If the burn is circumscribed, that is, anterior and posterior, the closed treatment would be better so that maceration of burn surface will not occur. However, if a Stryker frame is available and the patient can be turned easily and often, then open treatment can be used.

During the second phase of burn pathology, the treatment objectives are to maintain nitrogen balance, combat wound infection, and cover the full thickness areas. These objectives should be accomplished not in the above order, but concomitantly. One cannot succeed in raising the nitrogen balance without covering the burn and controlling sepsis.

A granulating base for grafting should be developed as quickly as possible; to do this, the burn eschar must be removed. If the patient is under closed treatment, this can be accomplished by immersing the patient in whirlpool baths every second day and redressing the burn wound.[3] (fig. 1, 2). Sepis thus becomes less of a problem and the burn wound is ready for grafting in 10 to 14 days. The early mobilization of joints via the buoyancy of the water is another advantage. If grafts are to be made, flexion surfaces are covered first; and if there is not enough skin to cover the burn area, homografts are utilized until autografts again become available. In our hands the hydrotherapeutic technic has been extremely successful in decreasing sepsis and graft-covering time, thus decreasing catabolism.

The physician must promote anabolization. These patients have a progressive anemia due to the initial destruction of red blood cells and the septic depression of bone marrow. Graft surgery may cause further loss of blood. Therefore, blood volume and hematocrit should be observed carefully and replaced to normal values. The intake of high caloric, high protein diet is of extreme importance since without it the patient will not anabolize and therefore the wound will not close.



Figure 1. Third degree burn of forearm showing marked exudation and infection.



Figure 2. The same burn wound after three days of hydrotherapy. Note the cleansing of wound and the healthy granulating base ready for grafting.

Tube feedings (forced feeding) may have to be instituted because of lack of appetite. Here, working in close harmony with the dietician, the physician must try to pacify the needs of the organism with the wants of the patient, who will crave foods that answer the problem of anabolism, for instance, ice cream for a child.

Protein and sodium may become low because of the hypotonicity developed after diuresis; therefore, the use of intravenous albumin with sodium chloride solution once or twice a week will aid healing. Loss of albumin per se should not be too great if the diet is adequate and if the plasma volume was replaced correctly in the first phase. Antibiotics, which were started initially, should be continued only if warranted by the later sensitivity studies. If the latter studies require a change of antibiotics, do so. Antibiotics are continued for not more than two weeks; thereafter they are of no value. These wounds are open and draining, and therefore should not need antibiotics. If they are septic, they clean up well with hydrotherapy.

Treatment of the third phase is simple, because at this time the patient is anabolizing. The small areas not grafted are taken care of and the patient is mobilized. With the Hubbard tank therapy, the joints should be fairly mobile. Here the aid of the physical therapist is mandatory. She sets up a plan of mobilization and rehabilitation. This means active and passive exercises and the teaching of progressive self help.[3]

In the fourth phase, the accent is on rehabilitation. Many times, in spite of all therapy, contractures with binding of the joints and neighboring structures will occur. These again, must be released by physiotherapy and surgical plastic procedures.

Summary

Burn physiology is complex, so therefore, it follows that the therapy of burns will be complex. However, if the physician will follow the physiologic principles applied above, he should be able to salvage even the patient with a 40 to 50 per cent burn.

REFERENCES

1. Artz, C. P., and Reiss, E.: Treatment of Burns, Philadelphia, W. B. Saunders Company, 1957.
2. Moore, F. D.: Metabolic Care of Surgical Patient, Philadelphia, W. B. Saunders Company, 1959.
3. Schumer, W.: Method for Removal or Debridement of Burn Wound Eschar, A.M.A. Arch. Surg. 29:630 (Oct.) 1959.

Malignant Melanoma

Cook County Hospital

Moderator:
Robert J. Freeark, M.D.
Director of Surgical Education, Cook County Hospital

Discussant:
George T. Pack, M.D.
Associate Clinical Professor of Surgery, Cornell University Medical School; Attending Surgeon, Memorial Center for Cancer and Allied Diseases; Clinician, Sloan Kettering Institute for Cancer Research, New York

Dr. Robert J. Freeark: Few problems in all of surgery are more perplexing, more controversial and in many respects more confused than those involving the care of patients with the so-called pigmented mole. Such patients are encountered by doctors in virtually all of the fields of medicine and surgery. The advice and treatment that these patients receive varies greatly with the experience and training of the physician consulted. There is a remarkable lack of agreement among experts in this field, and few are the men who can speak authoritatively and with conviction about these lesions whose natural course and response to treatment are so unpredictable.



Figure 1. Cavernous hemangioma

With us today is one of the outstanding authorities in this country and the world on the subject of the pigmented mole, and its ill behaved relative, the malignant melanoma. Dr. George Pack is a renowned clinician, surgeon, and investigator in the field of cancer. His lecture this evening at the Annual Scientific Meeting of the Illinois Surgical Society will be on the subject of "Carcinoma Susceptibility and Immunity" and is certain to reflect his long and brilliant experiences with the cancer problem. This morning however, we would like to confront him with a more specific topic and some of the clinical problems which characterize it.

We would like to begin with the presentation of some interesting and problematic cases of pigmented lesions of the skin and from this proceed to the management of cases of malignant melanoma.

We will show some slides and then ask Dr. Pack for his comments. (Slide 1) This was a lesion of short duration on the back of the thigh.

Presented during the Annual Clinical and Scientific Meeting of the Illinois Surgical Society.

It was deeply pigmented. The exact etiology was not known, but it was considered highly suspicious of malignant melanoma. The question that confronted the surgeons was the approach to be followed in establishing an exact diagnosis.

Dr. George T. Pack: In most instances the nature of the lesion is obvious enough so that the clinical diagnosis can be made without equivocation. In those few cases in which one is in doubt as to the character of the tumor and microscopical identification becomes necessary, an excisional biopsy should be done by preference. If it be small, a pigmented skin tumor should be excised rather than incised. There is no harm in performing an excisional biopsy so that the pathologist can be certain of his diagnosis; and a delay of a few days has never prejudiced the safety of the patient. There are instances such as this, where one might readily suspect melanoma and be happily surprised at the microscopic findings.

I do not do a three-dimensional tissue resection without proof of the histologic nature of the tumor. For an excisional biopsy of a suspected melanoma I would merely remove it, but not radically nor below the fascia. Not too long ago I had a patient from South Africa who noticed a black lesion on the under aspect of the toe. She had been referred to a surgeon who suspected melanoma. She caught the next plane out of Johannesburg. A simple excisional biopsy revealed it to be a hematoma. Without knowledge of the duration of the lesion, it is sometimes difficult to interpret from the clinical aspect alone.

Dr. Freeark: This was excised and, much to our surprise, on microscopic study turned out to be a thrombosed cavernous hemangioma.



Figure 2. Blue nevus. It simulates melanoma.

Dr. Pack: If the lesion were larger the diagnosis would have been more obvious.

Dr. Freeark: (Slide 2) This is a lesion on the buttock of a middle aged female. Biopsy showed this to be a blue nevus. Should we be concerned about a blue nevus?

Dr. Pack: These tumors are usually so small that incisional biopsy is unnecessary, and excisional biopsy is usually sufficient for treatment. The blue nevus occasionally becomes malignant. It is sometimes confused with malignant melanoma because it has a bluish-black cast and simulates melanoma somewhat, but it is situated more deeply in the skin and the epidermis over it is translucent. It is difficult to describe the difference in appearance of early melanoma and blue nevus, but the latter is a definitely deeper lesion. It is composed of the same type of mesodermal melanoblast that gives the blue tint in the skin of the rhesus monkey. Its occurrence in the white race is uncommon. It is found more frequently in colored people and more so in orientals. There is an interesting nevus (nevus of Ota) closely related to this which is commonly seen in Japan.

Dr. Freeark: Would you be content with a limited excision?

Dr. Pack: Yes.

Dr. Freeark: The next (Slide 3) is a very hairy nevus in a 7 year old child. How should that be treated?

Dr. Pack: The erroneous belief that the hairy nevus is always benign has appeared in medical literature; but the hairy nevus does have a definite tendency to undergo malignant changes, and therefore melanoma may originate from it. Perhaps the reason for the untrue statement that these massive lesions covering the trunk are invariably benign lies in an incomplete follow-up period of observation. I have a series of patients with melanoma developing in a large hairy nevus. The time to remove it is in infancy and childhood; it is usually excised segmentally. During childhood many of these large bathing-trunk nevi have junctional elements; but as the child grows older, the nevi maturate and lose a great deal of their junctional components and also may decrease in color. They leave true dermal nevi which are not dangerous.

A nevus of the type shown by this patient



Figure 3. Hairy nevus in 7 year old child.

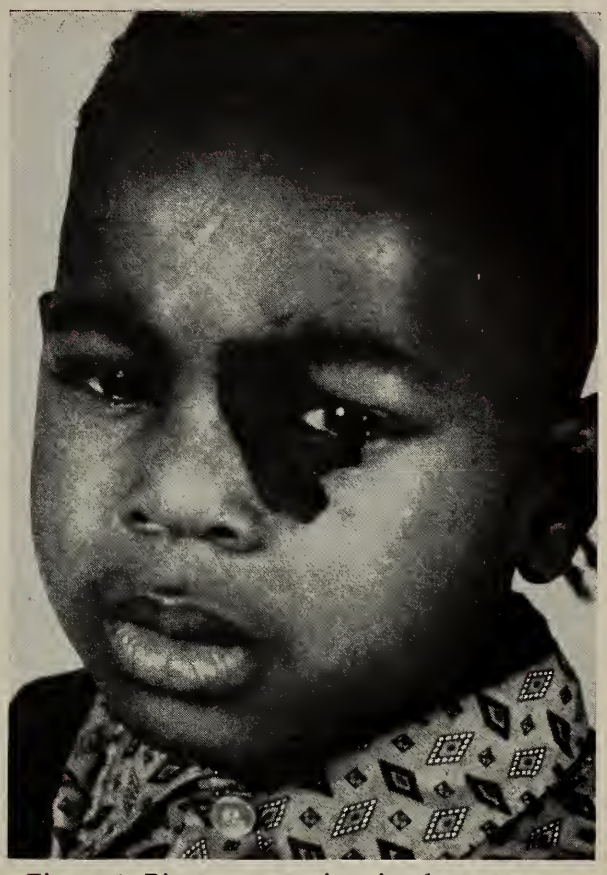


Figure 4. Biopsy proven junctional nevus.

would require surgical excision; I prefer to do this just before the child goes to school. I am not so influenced by the fear of malignant changes at this age as I am by the fact that the child then becomes a more intimate member of society and is sometimes subject to ridicule from his classmates. To avoid the trauma of unkind comments by the child's young and uninhibited classmates, it is well to take the lesion out before he starts school.

Dr. Freeark: Is the statement true that a nevus in a child never becomes malignant?

Dr. Pack: I have been misquoted as making that statement, but I never said just that specifically. As long as 30 years ago, I removed some very black pigmented nevi in children; the late great Dr. James Ewing made the definitive diagnosis of melanoma. However, in follow-ups we found that none of these children had metastases nor local recurrence. Because of the paradoxical end results as compared with adults, I went to Dr. Ewing and asked if there were any distinguishing features of this tumor. He said that some of these lesions were similar to melanoma because the cells were similar. I wrote an editorial about it and called it prepubertal melanoma. On the other hand, we have seen children four or five years of age with malignant melanoma capable of metastasizing to the regional lymph nodes. These cases are exceptional. I now prefer to say that, although metastases are possible and numerous case reports have attested to the possibility, we can still generalize by saying that it is seldom these pigmented tumors in children become malignant before the approach of puberty, when hormonal changes occur in the child.

Two colleagues of mine, pathologists in the Memorial Cancer Center, Dr. Sophie Spitz and Dr. Arthur C. Allen, some years ago studied these melanotic tumors in infancy and childhood more intensively and divided them into two separate categories: (1) true malignant melanoma which is no different from that seen in the adult, and (2) prepubertal or juvenile melanoma presenting certain histologic features they could identify under the microscope. Sometimes these features may be carried over into adult life, but it is seldom that this type becomes malignant. It is not necessarily a precancerous lesion, al-

though clinically it is often impossible to distinguish between the two, and the pathologist, regardless of the fact that this is an interesting classification, occasionally makes a slip.

Two of the prepurbital nevi presented here were in Negroes. This is not too common. I have studied nevi and melanomas in people of all races throughout the world; they are not frequent in the Negro. In the vast experience of the Memorial Hospital there were only 14 cases of malignant melanomas in Negroes, and at the Harlem Hospital in New York City I found only eight such cases in the records. Malignant melanomas in this country are more prone to occur in patients who are blond with blue eyes, or have pale, translucent skin. Redheads and people with a tendency to freekle, are peculiarly susceptible.

Dr. Freeark: (Slide 4) Punch biopsy on the dermatology service showed nevus in this Negro child. The problem: When one has reason to suspect a potentially dangerous lesion and when cosmetic considerations are foremost, how wide an excision do you recommend?

Dr. Pack: It would not require a wide excision. A lesion of this size can be removed and the defect corrected by a careful plastic procedure.

Dr. Freeark: Does it make any difference that we found this to be a junctional or hairy nevus?

Dr. Pack: Not at this age. Most of the junctional elements will disappear as the child grows older.

Dr. Freeark: (Slide 5) Now we come to the problem of real melanoma. This is a lesion on the heel of a 45 year old Negro male which on biopsy was determined to be malignant melanoma. Many of the nodes in the groin above the inguinal ligament were hard, fixed, and firm; and there was nodularity of the liver. We wonder about the management of the local lesion with distal metastases, as well as the role of isolated perfusion of chemotherapeutic agents.

Dr. Pack: The management of melanoma with metastases to the groin is a subject of considerable controversy. If the primary melanoma is situated close enough to the lymph nodes so that one can remove the tumor, the nodes, and the intervening tissues, complete surgical excision is feasible. That is what one does for carcinoma of the breast, and it works out very well there. But when a melanoma is situated remotely from the lymph nodes and may involve the entire extremity, surgical excision is less likely to be complete.

When melanoma does develop in Negroes, the sole of the foot is a relatively common location, and this may also be said for the subungual region. In all races, moles are relatively infrequent on the feet and melanomas are proportionately more common, so one might say that a mole on the foot should be given careful consideration before removing it prophylactically. Many pigmented lesions on the foot are not nevi. The sole and the heel are drained by lymphatics that penetrate the deep fascia and communicate with lymph nodes in the popliteal space. I can remember making ward rounds one day and seeing three patients who had melanoma on the foot with palpably involved popliteal nodes. If the tumor occurs on the dorsum of the foot, it usually skips these popliteal nodes intercalated along the deep lymphatic pathways. When a leg is amputated for melanoma, metastatic involvement of impalpable deep lymph nodes along these pathways is sometimes demonstrated.

The end results after major exarticulations of extremities for melanomas have been poor, not due to the impropriety of the operation nor to technic, but because of undue delay in instituting treatment. On too many occasions surgery becomes an amputation of desperation rather than an operation of hope. When nothing more can be done to preserve the extremity, we are compelled to do either a hip joint disarticulation with the deep iliac dissection or, in the case of the upper extremity, an interscapulothoracic amputation with lower neck dissection. Such measures may be necessary to get rid of a useless, painful, intolerable extremity. Before ever instituting such a disabling procedure for a patient with metastases in the groin and a primary melanoma on the foot, the surgeon utilizes the groin incision to slit the peritoneum and put an exploring hand within the peritoneal cavity and feel the liver and periaortic lymph nodes. If there are metastases to the liver, the plan for amputation should be abandoned and the patient allowed to walk on the previously condemned leg.

We have done elective groin dissection in the absence of evidence of groin metastasis; but with



Figure 5. Malignant melanoma on heel

the primary melanoma on the foot or toe, the results have been sometimes good and sometimes bad. Whenever an adequate groin dissection is done, there follows a certain degree of lymphedema of the extremity with lymph stasis and lymphectasia, the worst possible setting for recurrence of melanoma. If a toe is amputated for melanoma, or a melanoma of the foot, ankle, or lower leg is excised and skin grafted with concurrent or later groin dissection, the result may be good if cure obtains. But if recurrence develops distal to the groin after such conservative procedures, the patient is usually doomed because the ultimate result is diffuse melanomatosis. Then the amputation is attempted and often results in failure.

In earlier years it was my custom to take care of the primary melanoma by excision and skin grafting; and if there were no evidences of metastasis, I would wait six weeks, then do groin dissection. In 20 to 30 per cent of these patients we found microscopic evidence of melanoma in the regional nodes. This alerted us, and we thought it was a proper sequence. However, in many of these patients with cryptic metastases in groin nodes in which the discontinuous operations were performed, innumerable bluish nodules subsequently developed intradermally and in the subcutaneous tissues. The definitive five year cure rate by this procedure in patients with proved metastases in nodes was only 20 per cent.

The management of a primary malignant melanoma of the foot with proved, discrete lymphatic metastases in the groin remains a controversial problem. I am certainly willing to be shown the proper method, because I have attempted every conceivable sequence of surgical disciplines, but none of them have completely satisfied me. We have not been readily willing to carry out amputation at a high level at a stage when it might be possible to achieve a cure. The little black melanoma of the foot with metastasis to a femoral node is an dangerous in the average circumstances as osteogenic sarcoma of the femur. Yet, given a patient with a little black melanoma occurring on the foot with one single node in the groin containing metastasis, most surgeons are very loathe to amputate. Of course, it is just as bad to die of melanoma as of osteogenic sarcoma. Another mental block in this situation is the memory of a few exceptional cases wherein the melanoma of the foot and the groin metastases were successfully treated by discontinuous operations and the extremity preserved.

Dr. Freeark: What about perfusion and chemotherapy when there are liver metastases?

Dr. Pack: I presume you mean perfusion and chemotherapy of melanomatous metastases in the liver? We know that metastatic cancer in the liver is supplied by the hepatic arterial system, because postmortem specimens injected to produce casts of the vascular system, reveal that the hepatic artery penetrates throughout the metastases but the portal venous branches are shunted around the tumor. Therefore, the situation should be ideal for the administration of chemotherapeutic agents via the hepatic artery. The technic has been established, but the proper drugs are lacking. The technic is to dissect away the right epiploic artery with its omental attachment along the stomach, introduce a tiny plastic tube, and guide it in retrograde fashion upward into the hepatic artery. When the abdomen is closed, the vascular pedicle is brought out through the abdominal wall. After administering the chemotherapeutic drug in normal saline solution, slowly by Murphy drip, the plastic tube is withdrawn and the gastroepiploic artery ligated exterior to the abdominal wound, thus avoiding a secondary operation.

In the treatment of systemic melanomatosis we have attempted palliation by the administration of large doses of phenylalanine nitrogen mustard with subsequent bone marrow protection by autogenous bone marrow infusions. In the case of melanoma involving the extremities, the isolation-perfusion technic will cause regression of the tumor, which to date is a palliative effort. I am waiting for that happy day when the right

drug comes along to make this work meaningful. The only feature about this therapeutic discipline which I deplore is that I am aware of certain instances wherein this method has been chosen in preference to a possibly curative surgical procedure.

Dr. Freeark: This patient underwent isolated perfusion of the entire extremity in an attempt at palliation. Unfortunately, treatment was interrupted by the sudden and inexplicable death of the patient on the second postoperative day. He did have distant metastases.

Dr. Pack: The treatment here conceivably may have had no bearing on the patient's sudden death. In postmortem studies of our patients dying of malignant melanoma, 38 per cent had metastases to the brain, and 44 per cent had metastases to the heart. Either of these complications in the natural history of melanoma could have been responsible for the sudden demise.

Case 1

Dr. Ralph Bransky (surgical resident): This patient is an obese white lady 42 years of age. When she was 24, she smashed her finger and after a few weeks had no more trouble with it until she was 28 years old. Then a black spot which increased slowly in size developed on it and the fingernail disappeared. In 1953, 11 years after the first injury and 7 years after she noticed the black spot, she had occasional bleeding and pain in the finger, and she presented herself for medical care. Amputation was recommended and refused. In 1955 she appeared again, and this time she accepted amputation of the finger. The pathologic report was melanoma. The patient had clinically involved nodes in the axilla. She had an axillary and epitrochlear dissection done six weeks after the amputation. The tissue report on both dissections did not reveal metastatic tumor. She has been perfectly well since then and was last seen three months ago.

Dr. Freeark: Was the treatment adequate, or were we unusually fortunate in this case?

Dr. Pack: Melanoma varies in degree of malignancy just like any other cancer. It can be of low grade malignancy. These subungual melanomas or melanotic whitlows should be favorable for treatment, but the average patient coming to us has had three previous operative procedures before we see him. Many subungual melanomas are not pigmented. A halo of pigment around the base of the nail is pathognomonic for melanoma.

I question very much the relationship of trauma in this case; it might not even be the same nail. On memory stimulation many patients may recall a single instance of reputed-trauma to the site of the tumor. In this case the number of years elapsing between the trauma and appearance of the tumor rules out that factor. I seriously doubt that trauma converts a benign nevus into malignant melanoma. It is commonly believed that irritation of moles may precipitate the onset of melanoma. This sequence may be a misinterpretation of the facts. The ordinary nevus is a pretty stable structure, and it is not easy to disrupt it. Melanoma, on the contrary, is friable and vascular and very easily broken; this change may occur imperceptibly; and when the melanoma bleeds after a slight injury, the patient then believes the trauma is causal. In my opinion, melanoma is not due to injury. The patient may go to a doctor who removes a mole, throws it away without microscopic examination, and does not realize it is a melanoma until it recurs as such.

For the treatment of a subungual melanoma we remove not only the entire digit but also the major part of the corresponding metacarpal bone.

Dr. Freeark: What is the management of a pigmented lesion beneath the nail? Should it be biopsied?

Dr. Pack: It is very difficult to tell whether such a lesion is a hematoma or a melanoma. It is important to attach considerable significance to the history of the patient who can tell when he saw it and what change has occurred. I am content, in cases where I am in doubt, to watch the patient before doing surgery.

Case 2

Dr. Frank Banich (surgical resident): The patient is a 41 year old white male who presented with the complaint of a tumor on the right infraclavicular area of the chest wall. He stated that he had had it all his life. There was a flat, dark, non-hair-bearing lesion on the chest that in the past two months had grown in size and had thickened. On physical examination he was well nourished and well developed with a normal blood pressure and pulse. The lesion was located about 4 cm. below the middle one third

of the right clavicle. It was 4.5 cm. in diameter, raised 1.5 cm. above the skin surface. It was a jet black lesion with extensive cornification, and its boundaries showed serpiginous extension of black pigmentation. He also had in his right axilla a rubbery node 3 or 4 cm. in diameter, and a few shotty smaller nodes. There was nothing remarkable about the cervical region.

An en bloc dissection was done, widely excising the melanoma. The dissection was carried down through the pectoral fascia and muscles and included the axillary lymph nodes. The microscopic diagnosis was malignant melanoma with extensive regional lymph node metastases.

Dr. Freeark: We do not know the results in this case because the patient was operated on in 1956 and has been lost to follow-up. We would like your opinion on the proper management of such lesions of the trunk.

Dr. Pack: Two recent patients with melanoma in similar locations illustrate the principles involved. One was a woman with melanoma in the skin of the medial segment of the breast a short distance from the parasternal line. She had no palpably enlarged lymph nodes. She had a radical mastectomy and at the same time an internal mammary node dissection; one of the internal mammary nodes contained metastatic melanoma. In the patient Dr. Banich presented, on the basis of statistical evidence alone, if he had melanoma in the skin of the medial side of the chest with palpable metastases in the axilla, I would say he has a 60 per cent chance of metastasis to the internal mammary nodes. I believe he should have had an internal mammary node dissection, which is more important in his ultimate survival because this is the location from whence it can readily spread to the liver. The other patient I mentioned did not have melanoma in the skin of the medial aspect of the chest but in the pectoral region. We performed a combined radical neck and axillary dissection in continuity in association with a cleidectomy and removal of the pectoral muscles. The complete removal of the clavicle under these circumstances affords a much more complete dissection and does not greatly disable the patient.

Case 3

Dr. Robert Eberle (surgical resident): A 78 year old Negro female was seen last February with a four months' history of rectal bleeding and pain. This occurred originally only at the time of defecation, but she later passed enough blood periodically to require wearing a sanitary pad. Pain was present only on defecation. On physical examination she was a well developed, well nourished hypertensive woman. General examination was negative, except for a small hemorrhoidal tag protruding through the anus. Extending upward some 6 to 8 cm. into the rectum was a large tumor mass which was fixed anteriorly. Routine laboratory examinations were negative; her hemoglobin was 70%, and the chest x-ray film was negative. Liver profile was within normal limits as was intravenous pyelography. Biopsy revealed a malignant melanoma.

Dr. Pack: The anorectal canal is one of the worst locations for malignant melanoma. The oral mucosa is the only location that is worse. In a 1952 report of more than 1,200 cases of melanoma, only 19 were in the anal canal; all of these patients died. We were sufficiently impressed by these fatalities. We have been too conservative in our management of melanomas in this location, so we have lately adopted the policy of carrying out not only a radical abdominoperineal rectal dissection with bilateral groin node dissection but also a dissection of the pelvic lymph nodes, as in Wertheim's operation for uterine cancer. Even then, this disease is discouraging because the anorectal melanomas metastasize, not only via the lymphatics in the same way as carcinoma of the rectum, but upwards and through the perianal lymphatics to the medial superficial inguinal nodes. It is a serious situation and the outlook is none too good.

Dr. Freeark: Dr. Pack, it is difficult to conceive of anyone crowding so much worthwhile information on so controversial a topic into this brief hour. On behalf of the County Hospital as well as the Illinois Surgical Society, I would like to express our grateful appreciation for your fine discussion of these cases. We hope you will visit us again.

Columbus found a world, and had no chart save one that
Faith deciphered in the skies. — *G. Santayana*

CASE REPORTS

Nonfunctional Carcinoma Of the Adrenal Cortex — *Report of a Case*

R. W. Williams, M.D., and H. L. Lockner, M.D., *Chatsworth*

Nonfunctional carcinoma of the adrenal cortex is rare indeed. Because of the absence of diagnostic criteria, the process is usually discovered only when well advanced; therefore, the prognosis is guarded. The following case proved quite frustrating to the authors.

Case report

The patient was a 78 year old white male seen in our offices for the first time on Aug. 17, 1959. He stated that for the last six weeks, there had been a gradual onset of intermittent abdominal pain apparently not related to or affected by exercise, dietary intake, or change in position. The pain had become much worse during the previous week and was now associated with nocturia, dysuria, and a weight loss of five pounds. Fatigue and anorexia were prominent.

Physical examination showed expiratory wheezes over both lung fields, left ventricular hypertrophy, and a soft systolic murmur over the precordium. Blood pressure was 160/90, and pulse 84 and regular. The abdomen was normal, and rectal examination proved noncontributory. Because of the patient's severe distress, hospitalization was advised.

During the first admission the patient remained afebrile. Physical findings did not change. The laboratory reported 4,000,000 RBC, 12,800 WBC with normal differential, and a hemoglobin of 11.7 Gm. Blood sugar was 100 mg., and nonprotein nitrogen 60 mg. per cent. Urinalysis was normal. Chest films showed calcium in the aorta, and moderate fibrotic and emphysematous changes. Complete gastrointestinal series preceded by proctosigmoidoscopy were reported as normal except for a few sigmoid diverticula. Films of the lumbosacral spine did, however, reveal severe hypertrophic osteoarthritis with some narrowing of the bodies and calcification of discs. The patient was treated conservatively for anemia, arteriosclerosis, and dehydration. Because of the severe arthritic changes and associated pain, Medrol® in 4 mg. doses every eight hours was instituted. The patient was discharged on August 22 feeling somewhat better.

During the next 19 days the patient was followed closely in the office. He remained somewhat better for a time, but gradually the symptoms began to recur. By September 8 there was another seven pound weight loss and increasing lumbosacral pain. He was readmitted to the hospital on September 10 for cystoscopy and retrograde pyelography. Results of this examination showed some hydronephrosis of the left kidney, a small stricture of the left ureter, and early prostatic hypertrophy. Urine samples revealed many white blood cells, and cultures were positive for *E. coli*. The patient left the hospital on September 12, having been treated for pyelonephritis only.

The next three weeks brought regression of the pain. The urine cleared, and no weight loss was noted. Although the patient's general health

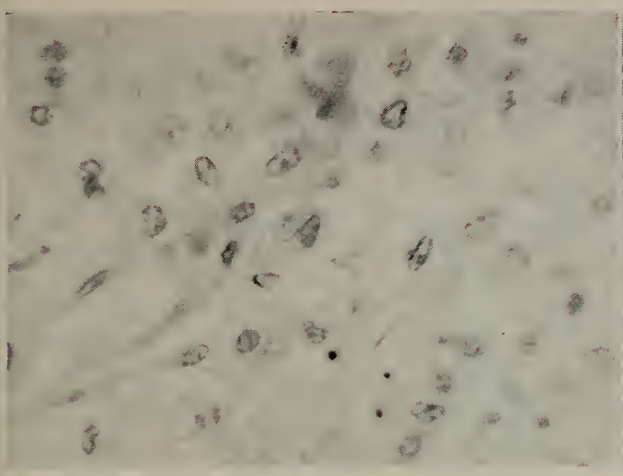


Figure 1. Carcinoma of adrenal cortex.

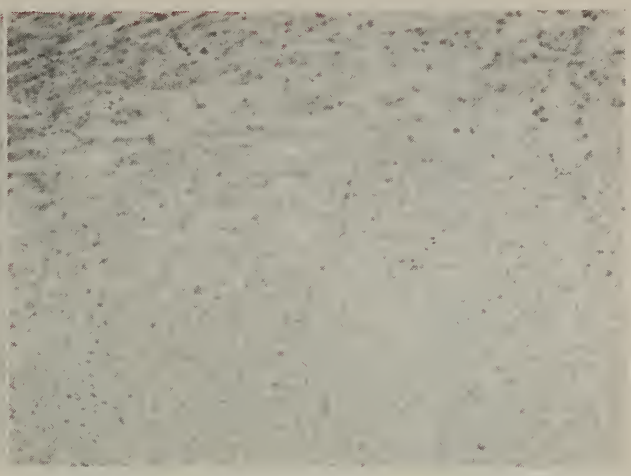


Figure 2. Metastasis of the carcinoma to liver.

failed to improve, the regression of symptoms was attributed to antibiotic and steroid therapy. On October 5, however, he was readmitted to the hospital because of severe back pain and dysuria.

Films of the lumbosacral spine showed a marked increase in the arthritic process previously reported. The day after admission, acid phosphatase was read at 6.1 Bodansky Units. This was confirmed three days later with new standards; the level at this time was 7.2. The diagnosis of carcinoma of the prostate was made and estrone, 2 mg. a day, intramuscularly, started. Within seven days the acid phosphatase level dropped to 0.9 B.U., but symptoms did not regress. Physical examination remained unchanged except for the onset of hepatomegaly. Despite treatment, the condition became worse. On October 27, following an episode of hyperpnea, cyanosis, and hypotension, the patient died.

Pathologic report

Gross. The abdominal cavity was filled with several liters of clear ascitic fluid. The liver was quite enlarged and filled with multiple metastatic nodules (fig. 1). The omentum also was involved. Other viscera appeared normal. Examination of the renal areas revealed a walnut-sized retroperitoneal mass above the right kidney. This was easily shelled out of the apparent capsule. The cut section had a yellowish appearance with hemorrhage and necrosis in the center. Microscopically, the diagnosis of primary carcinoma of the adrenal cortex was made (fig. 2). The prostate as well as the opposite adrenal gland were free of disease.

Discussion

On review, it was noted that the patient experienced several episodes of acute pyelonephritis. This appears compatible with the finding of Wood, Lees, and Rosenthal[1], in which they reviewed 27 cases reported since 1923. The most constant symptoms they noted were fever, flank pain, and weight loss. Many of these cases did, however, show either abnormalities of the pyelograms, masses in the abdomen, or both.

The absence of hyperadrenalism associated with such tumors is well documented.[2] We are, however, at a loss to explain the elevated acid phosphatase levels. It should be re-emphasized that this finding was confirmed against new standards in the laboratory. The return of this finding to normal following estrogen therapy is, of course, even more bewildering.

REFERENCES

1. Wood, K. F., Lees, F., and Rosenthal, F. D.: Carcinoma of the Adrenal Cortex without Endocrine Effects, Brit. J. Surg. 45:41, 1957.
2. Cottler, Z. R.: Nonhormonal Adrenal Cortical Carcinoma: Report of Case with 5 Year Survival and Relief of Hypertension, J. Urol. 60:363, 1948.

Genius is eternal patience. — *Michaelangelo*



Before ..... After

Correction of Mandibular Prognathism

Report of a Case

EDWARD C. THOMPSON, D.D.S.
and
JERRY A. BRADY, D.D.S.

VARIOUS METHODS have been described for surgical correction of the prognathic mandible.[1] One method which is becoming more widely used is bilateral subcondylar osteotomy.

Patients with this developmental deformity, the protruding lower jaw, experience difficulty in masticating food because of the obvious malocclusion of the teeth. They are unable to incise food with the anterior teeth, and what mastication is possible is limited to the posterior teeth. The endentulous patient presents an additional problem in that constructing functional dentures is impossible.

The unattractive appearance of the face is also a major consideration for corrective surgery. In some patients this deformity has resulted in shyness, self-consciousness or other personality problems. The patient's personality development coincident with his new appearance is of immeasurable value to him, and rewarding to the surgeon.

Report of case

On Dec. 2, 1959, a 28 year old male civil engineer was referred to Carle Clinic for evaluation and treatment of his severe mandibular prognathism.

From the Department of Oral Surgery, Carle Hospital Clinic, Urbana.

The patient was a well-developed, well-nourished young man. History and physical examination were essentially negative; blood pressure 122/82, pulse 76, temperature 98° F., respiration 18. X-ray surveys of the teeth, jaws, and chest were negative. The only abnormality was the pronounced mandibular prognathism.

Laboratory data: The hemoglobin was 14.2 Gms./100 cc: RBC 5 million/cu. mm.; WBC 6,100/cu. mm. with 55 per cent neutrophiles, 38 per cent lymphoctyes, 7 per cent monocytes, and adequate platelets. Urinalysis was alkaline, and was negative for sugar and albumin. The specific gravity was 1.002.



Figure 3. Preoperative relationship of the teeth.



Figures 1 (opposite page) and 2. Preoperative and postoperative views of correction of mandibular prognathism.

Before ..... After

Treatment and course

Impressions of the maxillary and mandibular teeth were taken to study and evaluate the planned postoperative occlusion of the teeth. The necessary preoperative adjusting and equilibration of the teeth were carried out.

On Dec. 28, 1959, the patient was admitted to the hospital where maxillary and mandibular dental arch bar splints were applied with stainless steel wire ligatures. These appliances were to be used to maintain the postoperative immobilization of the jaws in their new relationship. The patient was typed and cross-matched for blood, and preoperative antibiotic therapy instituted.

Operation

Anesthesia was induced with pentothal, nitrous oxide-oxygen, and a nasoendotracheal tube was inserted to maintain a patent airway.

The skin inferior to the angle of the right mandible was prepared, and the area draped to expose the operative site. A 5 cm. curved incision was made 2 cm. below and slightly anterior to the angle of the mandible. Bleeders were then ligated, and, by employing both blunt and sharp dissection, the inferior border of the mandible was exposed; care was exercised to avoid the mandibular branch of the facial nerve. The external maxillary vessels were reflected anteriorly, and

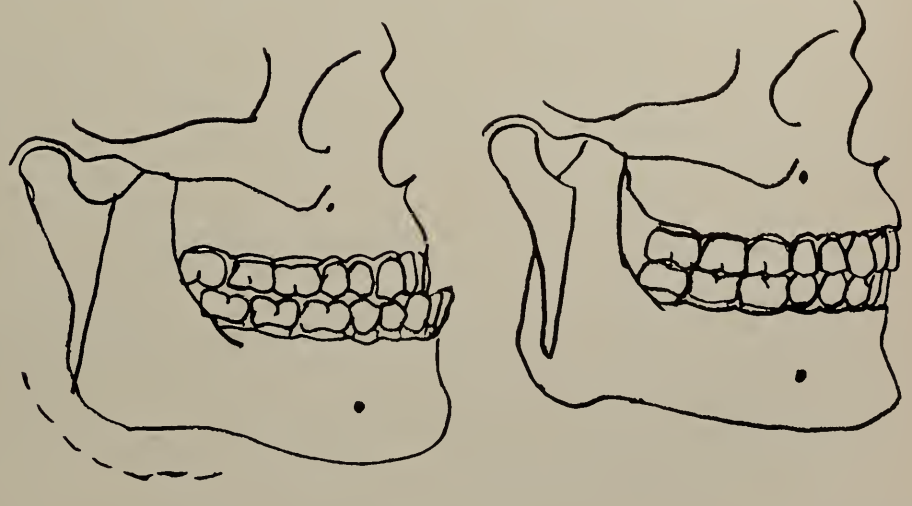


Figure 4. Sketch of subcondylar osteotomy method of correcting mandibular prognathism. (Courtesy of Dr. E. C. Hinds)

the masseter muscle freed and reflected superiorly, thus exposing the lateral surface of the mandibular ramus. The sigmoid notch was located, and, with an electric drill, an oblique cut was made which sectioned the ramus. The internal pterygoid muscle was partially reflected from the medial surface of the ramus to allow the posterior fragment of the ramus to be positioned laterally. The identical procedure was carried out on the left side. With both posterior fragments in lateral position the mandible was pushed posteriorly, and intraoral elastic ligatures were applied to immobilize the jaw in its new relationship. The masseter muscles were repositioned over the rami, and the operative sites closed in layers.

The nasoendotracheal tube was removed after the patient reacted to stimuli and questioning. The estimated blood loss was approximately 300 to 500 cc. The patient tolerated the procedure well and was taken to the recovery room in good condition.

Postoperative treatment

The patient was observed constantly for airway difficulties until he was fully oriented. Intravenous fluids were continued for 24 hours, when a limited oral liquid diet could be tolerated. The patient experienced only moderate pain which diminished in a few days. He was instructed how to cut the intraoral ligatures to avoid respiratory complications if he should become severely nauseated. The postoperative course was uneventful, and the patient was discharged from the hospital on Jan. 5, 1960.

For the following six weeks the patient tolerated his liquid diet well and was seen at one week intervals. At the end of the sixth week the intermaxillary ligatures were removed, mobilizing the jaws. The clinical union was satisfactory, and he appeared to have good but limited mandibular excursions. At four months postoperatively there were no abnormal findings. The patient's new dental occlusion and his mandibular movements were entirely satisfactory.

Discussion

This case demonstrates the esthetic and functional benefits available for patients with varying degrees of mandibular prognathism.

Some of the advantages of the subcondylar osteotomy operation are (1) injury to the inferior alveolar and facial nerves is avoided; (2) the body of the mandible is not involved; (3) there is no injury to or loss of teeth; (4) interosseus wiring is not required, and good clinical union occurs in four to six weeks; (5) the temporomandibular joint is not involved, and its relation is unchanged; and (6) open bite deformity is a rarity following this method of correction.

The disadvantages, fortunately, are few: the minimal external scarring and an average three hour's operating time.

REFERENCES

1. Thompson, E. C., and Jurgens, E. H.: Review of Surgical Procedures of Mandibular Prognathism, J. Oral Surg. 14: 143 (April) 1956.

Treasure trove

"The milk-cart rattled down the road and our Liz, a keen gardener, ran out with bucket and spade in search of treasure trove. 'You can't have that, Liz—I saw it first,' piped the lady next door, 'and anyway it's outside my house.' But Liz had beaten her to it. 'A clear infringement of manorial rights,' commented the lawyer across the road when he heard of the incident." *In England Now. The Lancet 1:1291 (June 11) 1960.*

Exchange Transfusion in Neonatal Jaundice Due to Congenital Spherocytosis

Philip L. Wachtel, M.D.*, *Freeport*

Congenital spherocytosis is a well known familial disorder generally recognized in childhood or early adult life by the presence of symptoms related to a chronic hemolytic process. Recently, however, an increasing number of reports have shown that the disease may be apparent even in the newborn. Medical literature now contains 19 documented cases of clinical jaundice due to congenital spherocytosis recognized in infants less than 14 days old.[1-10] Other cases have been described with a history of neonatal jaundice,[10-13] but the diagnosis was not made until later. Kernicterus has developed in at least one infant[4] and possibly in three others.[12,13] Eight[5-9] have been treated by exchange transfusions. One of these[9] had signs of impending brain damage which disappeared after treatment.

The purpose of this paper is to report another case requiring exchange transfusion, with comments on the diagnosis and treatment.

Case report

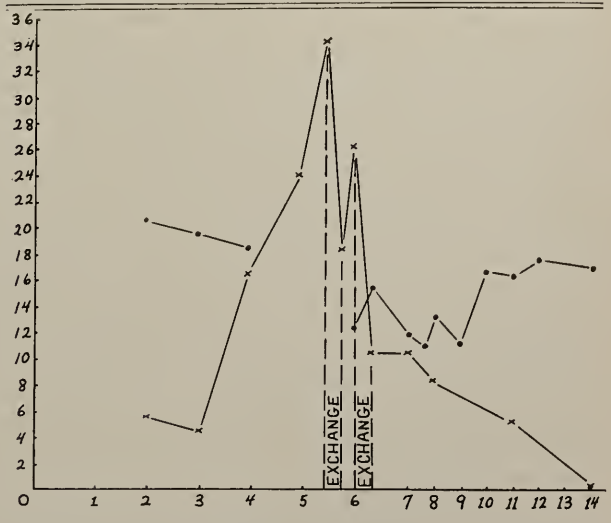
K. J., a white female, was born Jan. 20, 1959, weighing 7 pounds, 15 ounces. On January 22, jaundice was noted. The total serum bilirubin was 5.8 mg. per cent. The hemoglobin was 20.8 Gm. per 100 ml. The mother had blood type O Rh positive. The patient was type O Rh negative. Direct Coomb's test was negative, as was the indirect Coomb's test utilizing the mother's serum and the baby's cells. At this time the father was found to have been intermittently jaundiced prior to splenectomy at age 8.

By January 24 the bilirubin had risen to 16.6 mg. per cent. The red blood cell count was 4,470,000. The hemoglobin was 18.4 Gm. per 100 ml. Reticulocyte count was 8 per cent. A peripheral smear revealed many spherocytes. The red blood cell fragility test showed: Patient — hemolysis beginning at 0.46 per cent saline and complete at 0.36 per cent saline; control — hemolysis beginning at 0.46 per cent saline and complete at 0.30 per cent saline. On January 25 the bilirubin had risen to 24.2 mg. per cent, and four hours later, at the time of exchange, was 34.6 mg. per cent. Exchange transfusion was performed with 500 ml. whole blood, and was repeated on January 26 with results as shown in table 1.

Aside from the presence of jaundice, the patient appeared well throughout her hospital stay. There were no signs of kernicterus. At no time was the spleen enlarged to palpation.

During the past year the patient has remained well. Her growth and development have been

Table 1. — Serum Bilirubin Levels in Infant with Congenital Spherocytosis.



Days of Life. Hemoglobin Gm./100 ml. •————•
Bilirubin mg./100 ml. x————x

*From the Freeport Clinic

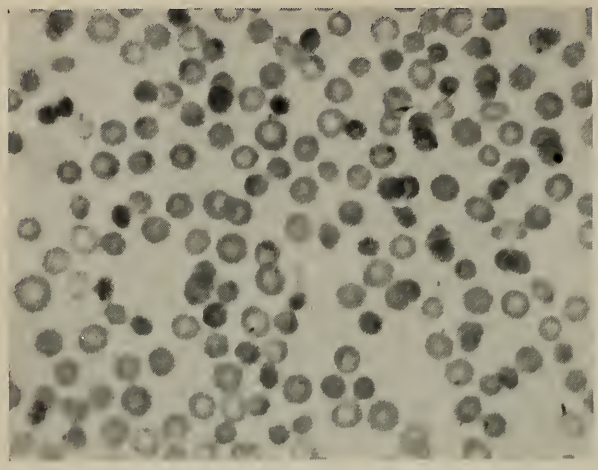


Figure 1. Peripheral blood smear indicating spherocytosis.

normal. There has been no palpable splenic enlargement. Her hemoglobin has remained constant between 8 and 11 Gm. The reticulocyte count has ranged from 1.5 per cent to 8 per cent. The highest serum bilirubin obtained was 1.6 mg. per cent indirect and 0.7 per cent direct on Oct. 29, 1959. The peripheral blood smear now shows many spheroeytes as illustrated in figure 2. A fragility test on Jan. 20, 1960, showed: Patient — hemolysis beginning at 0.64 per cent saline and complete at 0.40 per cent saline; control — hemolysis beginning at 0.42 per cent and complete at 0.36 per cent saline. A fragility test after 24 hours incubation showed: Patient — hemolysis present at 0.85 per cent and eomplete at 0.42 per eent saline; control — hemolysis beginning at 0.60 per cent and complete at 0.42 per cent saline.

Comment

The differential diagnosis of jaundice in the newborn requires consideration of several conditions including physiologie jaundice, erythroblastosis fetalis, ABO hemolytic disease, sepsis, neonatal hepatitis, eongenital nonspherocytic hemolytie anemia, cytomegalic inclusion disease, toxoplasmosis, syphilis, and eongenital spherocytosis. Most of these ean be identified readily by application of the appropriate examinations.

Unfortunately, however, there is no reliable test for eongenital spherocytosis at this age. Early diagnosis would be very diffienlt in most eases if it were not for the usual presence of a positive family history. Congenital spheroeytosis is inherited as a Mendelian dominant characteristie and should be found in one of the parents. Several instances of the disease have been reported without such a history.[2,9,14,15]

Red cell fragility frequently appears normal, as it did in this case. This has been thought to be due to the presenee of fetal macrocytes which are unusually resistent to destruction in hypotonie saline.[16] If so, in the future, use of normal newborn blood as the control might produce better test results.

The peripheral blood smear is not diagnostic since spherocytes are frequently seen in the more eommon condition of ABO incompatibility. Differentiation of these two diseases may, in fact, depend upon time alone. There is, at present, no widely recognized, reliable test for ABO hemolytic disease; but its manifestations are transient, while those of congenital spherocytosis are permanent in the absence of treatment.

Exchange transfusion, properly employed, is known to be effective in preventing brain damage due to elevated serum bilirubin, whatever the cause. In newborn jaundiee due to congenital spheroeytosis, however, the exehange serves not only to prevent kernieterus, but to provide the infant with normal red blood cells that survive to guard against the dangers of anemia or aplastic erises the first few weeks or months of life.

In the ease reported, serum bilirubin levels were allowed to go dangerously high sinee we were at first unaware of the family history and were poorly prepared for an early exchange transfusion. It is suggested that, with a family history of congenital spheroeytosis, preparations be made just as they would be in expeetation of delivery of an erythroblastotie child.

Splenectomy is known to enre the clinieal manifestations of eongenital spherocytosis, and some authorities[7] have apparently considered neonatal jaundice an indication for early operation. However, in view of the possible hazards of early splenectomy,[3,17] it is well to note that this child and the others reported have remained well after an exchange transfusion for follow-up periods as long as 22 months. Neonatal jaundice due to congenital spherocytosis is not, in itself, an indication for early splenectomy.

REFERENCES

1. Burman, D.: Congenital Spherocytosis in Infancy, Arch. Dis. Childhood 33:335 (Aug.) 1958.
2. Abt, R. F.: Hemolytic Disease in Infants, Am. J. Dis. Child. 60:812 (Oct.) 1940.

3. King, H., and Shumacker, H. B.: Splenic Studies. 1. Susceptibility to Infection after Splenectomy Performed in Infancy, Ann. Surg. 136:239 (Aug.) 1952.
4. Stenstrom, J. D., and Ford, H. S.: Hereditary Spherocytosis, Canad. M.A.J. 74:34 (Jan. 1) 1956.
5. Hindman, S.: Clinical Conference at St. Christopher's Hospital for Children, Philadelphia, J. Pediat. 44:213 (Feb.) 1954.
6. Stamey, C., and Diamond, L.: Congenital Hemolytic Anemia in the Newborn. Relationship to Kernicterus, A.M.A. Am. J. Dis. Child. 94:616 (Dec.) 1957.
7. Pont, M. E., Jones, J. A., and Bulen, J. A.: Exchange Transfusion in a Neonatal Crisis of Congenital Hemolytic Anemia, A.M.A. Am. J. Dis. Child. 99:231 (Feb.) 1960.
8. Smith, J., and Franklin, A. W.: Congenital Familial Spherocytosis with Neonatal Hyperbilirubinemia Treated by Exchange Transfusion, Proc. Roy. Soc. Med. 50:707 (Sept.) 1957.
9. Betke, K.: Icterus neonatorum gravis als Manifestation einer hereditaren Spharocytose, Ztschr. Kinderh. 78:359, 1956.
10. Newns, G.: Acholurie Jaundice in Infancy, Great Ormond Street J. 1:32, 1951.
11. Dawson, L.: Hemolytic Icterus, Brit. M. J. 1:921 (May 30) 1931.
12. Bernard, J., Boiron, M., and Estager, J.: Une grande famille hemolytique: Treize cas de maladie de Minkowski-Chauffard observes dans la meme fratrie, Semaine hop. Paris 28:3741 (Dec.) 1952.
13. Turman, C. M., Vaughan, V. C., and Shelly, R. M.: Incidence of Hemolytic Disease of the Newborn due to A or B Incompatibility, Am. J. Obst. & Gynec. 71:885 (April) 1956.
14. Young, L. E.: Hereditary Spherocytosis, Am. J. Med. 18:486 (Mar.) 1955.
15. Fallon, M.: Jaundice and Conditions Associated with this Phenomenon, J. Pediat. 23:271 (Dec.) 1943.
16. Erlandson, M., and Hilgartner, M.: Hemolytic Disease in the Neonatal Period and Early Infancy, J. Pediat. 54:566 (May) 1959.
17. Smith, C. H., Erlandson, M. E., Schulman, J., and Stern, G.: Hazard of Severe Infections in Splenectomized Infants and Children, Am. J. Med. 22:390 (Mar.) 1957.

The "dumping syndrome"

Following gastric surgery approximately 15 per cent of patients develop a group of postprandial symptoms which comprise what has been termed the "dumping syndrome." Shortly after a meal these patients develop epigastric fullness, severe weakness, tachycardia, sweating, and at times nausea and vomiting and diarrhea. It was formerly thought that all these symptoms were attributable to the rapid passage of the ingested food from the gastric pouch into the small intestine, and the patient's distress resulted from distention and hypermotility. It is now recognized that there are additional factors such as hyperosmolarity of the food which increases distention and motility by drawing fluid into the lumen of the bowel. This mechanism may also produce a reduced blood volume and serum potassium level. A few patients develop late dumping which is characterized by symptoms of tachycardia, sweating, and weakness about an hour after eating and is attributable to an early hyperglycemia followed by a precipitous fall in the blood sugar to hypoglycemia levels.

Fortunately these dumping symptoms are short-lived in the majority of patients and disappear spontaneously in a few weeks. In some, however, they are persistent and incapacitating. It has been recommended that the diet consist of small dry feedings devoid of concentrated sugar. Fluids should be avoided while eating and taken only between meals. Lying down for a few minutes after breakfast when postprandial weakness is greatest is frequently a necessity during the early period of treatment. Reassurance, and mild sedatives and anticholinergics should be given a trial. Frequently these are powerful adjuncts to treatment but rarely specific. *C. W. Wirts, M.D. Problems in Patient Management Following Gastric Surgery. Am.J. Gastroenterol. May 1960.*

Clinical Evaluation of Soma

B. B. Neuchiller, M.D. *Woodstock*

The commonest symptom which brings the patient to the doctor is pain, and relief of it becomes a primary objective. Even among the well adjusted, it is seldom borne cheerfully, however stoically, and those who suffer demand relief more than a lot of attention. While low-grade pain serves a physiologic function in the defense mechanism and is frequently a helpful clue in diagnosis, the great bulk of pain serves no useful purpose. Indeed, catering as it does to the dehabilitation of the patient, severe and prolonged pain often impedes, and sometimes defeats, the recovery process.

In a large segment of patients seen by the general practitioner, pain is directly the result of muscle spasm, and whatever the etiology, the relaxation of the muscle and relief of pain is the first consideration. Carisoprodol possesses analgesic and muscle relaxant properties[1], and this paper reports on an evaluation of its usefulness for relief of pain and stiffness in muscles, joints and bursae, in a series of patients in whom this syndrome was predominant.

Method

A series of 43 selected patients were treated with carisoprodol. The patients were classified according to the condition or syndrome of which they complained or was actually diagnosed.

TABLE 1.—Diagnostic Groups

Diagnosis	No. of Patients	Male	Female
Fibrositis	8	1	7
Sacro-iliac and lumbar syndromes	7	3	4
Myositis	6	5	1
Ligamental strain	8	4	4
Torticollis	5	1	4
Bursitis	4	1	3
Miscellaneous group*	5	3	2
Totals	43	18	25

*Includes: neuralgia, tendinitis, alcoholic polyneuritis, derangement of knee joint, and sprain.

Carisoprodol was supplied as Soma™ by Wallace Laboratories, New Brunswick, N.J.

The youngest patient in the series was 16 years of age and the eldest 76; the majority were 30 to 50 years old. For most patients one tablet was given four times daily, but five received two tablets four times daily, and one received one tablet three times daily. All patients received medication for at least seven days, but the duration of treatment varied up to 28 days.

Results

Thirty nine or over 90 per cent of the 43 patients obtained definite relief with carisoprodol, 12 had complete remission of symptoms, and 21 experienced great or substantial relief. Of the four who were not helped, three were found to require surgical correction. Since pain in most of these patients was associated with muscle spasm, relief was attributed to the relaxant, as well as the analgesic properties of the drug.

TABLE 2.—Evaluation of Results

Diagnostic Group	Relief on Carisoprodol Complete	Partial	None	Total
Fibrositis	1	7		8
Sacro-iliac and lumbar syndromes	3	3	2	8
Myositis	4	3		7
Ligamental strain		6		6
Torticollis	2	2	1	5
Bursitis		4		4
Miscellaneous group	2	2	1	5
Totals	12 (28%)	27 (63%)	4 (9%)	43 (100%)

Of the 43 patients involved in the series, only four experienced side effects, and these were mild in nature. Two complained of drowsiness and two of dizziness, which was relieved by lowering the dosage of the drug. Carisoprodol is, therefore, safe, relatively non-toxic and in this series showed no serious untoward side effects.

Discussion

In busy routine practice the general practitioner must deal frequently and promptly with pain of musculo-skeletal origin even before the

underlying cause is determined. The pathologic condition is not found in every case and, if present, is not always amenable to correction. In dealing with this type of pain it is obvious that a safe, oral, non-addicting drug would be a welcome boon to both patients and physicians. This series of 43 selected patients, in whom muscles, ligaments, or bursae were involved in painful syndrome were treated with carisoprodol, with rewarding results.

Forty-three selected patients suffering from pain and muscle spams were treated with carisoprodol. Relief was obtained in all but four cases; 39 or over 90 per cent obtained definite relief with carisoprodol. Of the four treatment failures, three required surgery. Side effects from carisoprodol were minimal and mild, and were relieved by lowering the dosage.

REFERENCES

1. Berger, F. M.: The Pharmacology and Clinical Usefulness of Carisoprodol, Detroit, Wayne State University Press. 1959.

Beginning Next Month . . .

THE VIEW BOX

A diagnostic quiz feature

from

COOK COUNTY HOSPITAL

The Program of Forensic Pathology In the State of Illinois

Edwin F. Hirsch, M.D., *Chicago*

The Constitution of the State of Illinois, adopted in 1870, directed that "every County shall elect a Coroner for a term of four years" but did not specify his duties and authority. The Coroners' Act of 1874 defined the duties and responsibilities of the office. The General Assemblies between 1881 and 1941, over a span of 60 years, added only six sections to the Coroners' Act, but none of these gave specific instructions about the procedures for the necropsy of bodies when death has resulted from real or suspected violence. When the Coroners' Act was placed on the statutes in 1874, modern scientific aids (forensic pathology) had not been developed. An inclusive system for this needs pathologists trained in forensic pathology to make the necropsy examinations, and laboratories for toxicology, tissue processing, and other procedures.

Legislation requested

Legislative measures to improve the quality of the medical examinations for coroners of the state had been urged for many years by the Institute of Medicine of Chicago. Then in 1952 the Chicago Medical and the Illinois State Medical societies came to grips with the problem, and a committee was appointed by the state society to determine some positive action. About this time the Association of Coroners of the State of Illinois also expressed an interest in legislation to more clearly define the functions of the coroner's office and to improve the quality of the medical examinations. A committee of each group joined in discussions, decided to adjust any differences, and united to sponsor constructive legislation.

Any legislative revision of the Coroners' Act must include all of the 102 counties of the state. To meet the great range of coroner workloads in the counties, a division of counties on the basis of population seemed logical; and as discussions on legislation progressed, counties of more than 500,000 population were designated as Class I counties, and those not exceeding 500,000 population were designated as Class II counties.

Two bills, each complimentary to the other, were drafted and on March 9, 1955, were introduced to the General Assembly by Sen. Albert Scott of Canton and others. They were designated as Senate Bill 247 and Senate Bill 248. Senate Bill 247 defined more clearly the cases of death which belong in the jurisdiction of the coroner; specified coroner's juries only for cases of suicide, homicide, and accidental death, thus saving the cost of unnecessary coroner's juries for a county; provided that the medical examinations be made by a physician duly licensed to practice medicine in all of its branches and, wherever possible, by one having special training in pathology; and specified that the appointment of these examiners in Class I counties be made by the coroner while those in Class II be made by the director of the Illinois Department of Public Health in consultation with the elected coroner of each county. Coroners and the director of public health, in this plan, thus cooperate in improving the quality of the medical examinations of coroner cases throughout the state, and in giving groups of counties the benefits of improved medical examiner services, where each alone would have difficulty in obtaining a qualified examiner.

Senate Bill 247 included further directives for the medical examination of a death under mysterious circumstances, clearance by the coroner when the body is to be cremated, and several other clarifying instructions.

Senate Bill 248 provided necropsy service to Class II counties by consultation with the elected coroners through the Department of Public Health. It also specified the appointment of an Advisory Board by the Governor to consider ways and means for improving the quality of these

services throughout the state. This Advisory Board of nine members was constituted to include three physicians, three elected coroners and three lay persons acquainted with the problems of forensic medicine

Both bills passed the Senate and the House of Representatives by wide margins. The Governor signed Senate Bill 248 but later vetoed Senate Bill 247. The committee of the Illinois State Medical Society again met with representatives of the Illinois Association of Coroners at the Sherman Hotel, Chicago, on Oct. 20, 1956, suggested minor changes in the wording of the vetoed bill, and decided to introduce the revised form into the next General Assembly (1957).

The Advisory Board on Necropsy Services to Coroners, appointed by Gov. William G. Stratton, held its organization meeting at the Hotel Leland, Springfield, on January 18, 1956. At this first meeting, the proposed legislation was discussed, and later the board voted to support but, in good judgment, decided not to sponsor the bill. This Senate Bill 63 passed the General Assembly and was signed by Governor Stratton. Continuing with legislation recommended by the advisory board, the last General Assembly appropriated funds to establish toxicologic laboratories for the coroners, exclusive of Cook County, one at Springfield for the lower tier of counties and one in the branch laboratory in Chicago for the northern tier. These provisions for the coroners are in process of development.

Duties of advisory board

The Advisory Board on Necropsy Services to Coroners is charged with the responsibility to counsel and advise with the director of public health on the administration of the Coroners Act approved Feb. 6, 1874, as amended, and to render medical assistance and advice to the coroners of the State of Illinois. At the organization meeting of the board, the hope was expressed that this group would work together to the advantage of all communities and improve the quality of the medical examinations for the county coroners. It is heartwarming to say that a mutual confidence has prevailed in the board, and during the four years of service, real progress and understanding among the 101 downstate coroners have been realized.

Many questions on policy and procedure have been presented for board consideration and decision. Under its guidance two manuals have been prepared and distributed. The first was for the coroners' physicians; the second was a guide for the coroners in the duties of their office. A third, in process, is on the technic of the necropsy. The Advisory Board continually seeks ways and means to realize more fully the objectives for which it was created. At the organization meeting of the board on Jan. 18, 1956, Doctor O. K. Sagen of the Department of Public Health made the significant statement that the success of the entire program in the state rested heavily upon the accomplishments of the advisory board. In retrospect, the board has served realistically, but obviously no health service in any state can function and develop without the positive support of physicians, and especially organized medical societies.

Improving medical examinations

Progress in improving the quality of medical examinations for coroners of the 101 downstate counties was reflected into Cook County and was appreciated by Coroner Walter McCarron. He realized that the quality of the medical examinations of his office should be improved, and his request for help from Chicago medicine resulted in the assemblage of an *ad hoc* committee composed of the deans of the five medical schools, a representative of the Institute of Medicine of Chicago, and the president of the Chicago Medical Society. This *ad hoc* committee met on July 1, 1957, with Coroner McCarron and offered five recommendations: (1) the appointment of a full-time pathologist with special training in forensic pathology, and other qualified assistants sufficient for the functions of the medical examinations; (2) the construction or organization of a laboratory of forensic pathology; (3) the appointment of pathologists as coroner's physicians; (4) the procurement of an adequate budget for these purposes; and (5) the appointment of a Citizens Advisory Committee consisting of recognized professional men in medicine and law, and influential civic-minded laymen for consultation and advice. The *ad hoc* committee obtained further information on the programs for the medicolegal investigations of real or suspected unnatural deaths as conducted currently in other large cities of the United States and compared them with the Cook County system. On Dec. 31, 1957, the *ad hoc*

committee reported to Coroner McCarron on the results of this study, reiterated its previous recommendations, and urged the implementation of these recommendations. Coroner McCarron on April 17, 1958, expressed appreciation for the thorough study made by the *ad hoc* committee and stated that the recommendations had been sent to all members of the Board of Commissioners of Cook County. Upon request, the details of the recommendations were discussed with him on April 28, and immediately he appointed a Citizens Advisory Committee to make a study of them.

The Citizens Advisory Committee met with Coroner McCarron and his representatives on June 18, 1958. The coroner reiterated his purpose to improve the quality of the medical examinations of his office and to keep this portion of his office free from political influences. Subcommittees of the Citizens Advisory Committee were appointed to examine and make recommendations in relation to facilities, organization, and legal aspects.

Soon afterward, the Committee was informed that the present County Morgue building would become available after about two years for complete reconstruction into an Institute of Forensic Pathology for the coroner of Cook County. Mr. Earl Kribben (deceased during these activities) gave devoted service to this phase of the program and secured architectural plans and cost estimates for the revision of the buildings. These plans envision the housing of the toxicology laboratories, the laboratories for the necropsies, offices, inquest rooms, and other facilities.

The subcommittee on organization of personnel proposed the selection and appointment by the coroner of a full-time certified pathologist with specific training and practical experience in forensic pathology. He should assume the responsibilities connected with the medical examinations of the coroner's office, the total organization of the professional and non-professional personnel of this branch of the office, and develop the laboratories required for an outstanding institute of forensic pathology for the coroner. The subcommittee charged with these responsibilities spent much time and effort in planning this comprehensive program and in the search for a pathologist. Dr. Joseph E. Campbell of Philadelphia was secured and appointed to this position by Coroner McCarron effective Aug. 1, 1959.

The subcommittee on the legal aspects found no obstructing difficulties in the further development of the program proposed by the Citizen's Advisory Committee to Coroner Walter McCarron. The results of several meetings and informal discussions of the Citizen's Advisory Committee with the County Commissioners and Coroner Walter McCarron are productive beyond all expectation. The reconstruction of the County Morgue building is expected to proceed in two stages: (1) an immediate modernization of the space now assigned to the Coroner, and (2) a much more extensive building reconstruction in about two years when the current needs of Cook County Hospital have been met by other building facilities. A bond issue of $750,000 for revision purposes was approved by the voters at the November 1959 election.

Much remains to be done to realize in a modest way the objectives recommended by the Citizen's Advisory Board to Coroner McCarron. The report by the Chicago Crime Commission of July 10, 1959, commends Coroner McCarron for this forward step to improve the quality of the medical examinations of his office. The medical profession looks upon this program with satisfaction and great hope that objectives projected years ago presently will be realized.

The opportunities now apparent in Chicago and in the State of Illinois for growth and potential leadership in forensic pathology and forensic medicine should be seized upon and given enthusiastic support.

Set me a task in which I can put something of my very self, and it is a task no longer; it is joy; it is art. — *Bliss Carman*

The Hospital Emergency Room

James H. Cross, M.D., *Chicago*

The hospital emergency room often is in a dilemma. The public expects, at a moment's notice, the latest in scientific medical care, available immediately but has practically no realization of the tremendous organizational and financial problems involved. From a public relations standpoint, the hospital's reputation can be made or broken on complex decisions that are made on short notice.

At the outset we must clarify what we mean by an emergency. A patient may consider a splinter in his finger an emergency. A true emergency is a medical problem involving usually a respiratory obstruction, circulatory failure, hemorrhage or serious accident.

Obviously there are differences between an emergency room in a large charity county hospital and one in a smaller private specialty hospital. A community hospital may serve an industrial area and treat mostly industrial injuries, or it may be in a congested traffic center where there are many automobile casualties. All these factors must be considered in planning the emergency room.

Further, in some hospitals, there is no special outpatient department, and it may be desirable to extend outpatient care in conjunction with emergency care. In addition, the emergency room in many smaller hospitals, is used for lesser type surgical procedures. At Community Memorial General Hospital, La Grange, it also serves as an outpatient area and as an outpatient minor surgical room. In general, however, the hospital emergency room is outlined primarily for traumatic or medical emergencies.

Location

In architectural planning for an emergency room, certain basic principles must be kept in mind. The location should be accessible to ambulances, with an unobstructed driveway, and the entrance clearly marked and well lighted.

The emergency room itself should be away from the main entrance of the hospital and, if possible, adjacent to the x-ray department and laboratory. Not only should ancillary services be physically adjacent to the emergency room, but there should be an arrangement as well whereby prompt functional service is available.

The amount of floor space allotted to the emergency room should, of course, depend upon location and size of hospital and the anticipated patient load. Ideally, there should be a treatment room, a minor operating room that can be kept aseptic, and adjacent examination and observation rooms. If combined outpatient rooms are utilized, provision should be made for preventing traffic in and out of the aseptic room. Ideally, there should be a waiting room with facilities for the police to interview relatives, and with telephone facilities for the public and the press.

In many older hospitals the emergency room consists of a single room which is used to per-

form a variety of functions, ranging from the treatment of a scratch at one moment, to the care of a patient with multiple severe injuries immediately thereafter.

Equipment and supplies

Certain equipment is essential for any emergency room. The patient table preferably should be the cart type that will allow movement for diagnostic procedures and to the wards without necessity of lifting the patient too often. There must be supply and instrument cabinets and some type of dressing cart. Oxygen and suction, preferably the wall type, must be instantly available. A sink and disposal unit is also basic. In one-room units, the nurse needs a desk for supplies and records, with telephone facilities, but if there are several rooms these facilities should be elsewhere to maintain the aseptic character of the room. A refrigerator is especially desirable.

Resuscitation equipment and medications must be readily accessible and clearly labeled. One of the artificial respirators may save a life, and, of course, airways and intubation sets are necessary. A tracheotomy tray likewise must be easily accessible. Means for circulatory resuscitation must be at hand. This includes plasma or plasma substitutes, saline and glucose infusions, and vasoconstrictors. Cut-down sets must be in the room. Other basic supplies consist of splints, prep trays, suture trays, gastric lavage sets, tourniquets, an eye tray, a small autoclave or sterilizer, and the usual basic instruments and solutions on the dressing cart. Mayo stands or similar trays are essential, as well as good lighting facilities. A considerable array of accessory supplies also must be available.

Staff

The nurse in charge of the emergency room should be physically strong, because the work may be quite arduous. Moreover, the nurse should desire this assignment and be one who takes a keen interest in resuscitation procedures. The number of nurses depends on the patient load. In small hospitals it might be necessary for the nurse to perform other duties, although if at all possible this should be avoided. An aide is essential, and this position is best filled by a male who can help lift and do other heavy jobs.

Medical staff organization of the emergency room is a controversial topic among doctors. There *must be a physician available at all times.* When a hospital has an adequate house staff, a resident who will always be available should be assigned to the emergency room. He should be well trained to handle traumatic cases and must realize that the staff physician must be called before any definitive therapy is instituted.

If the hospital is without a house staff, then some system must be set up whereby the staff men, on a rotation basis, assume responsibility of being in the hospital to cover the emergency room. In small hospitals it might be necessary for all members of the staff to rotate through 24 hour duty periods to insure adequate coverage.

The ideal procedure, I believe, is to offer all staff members interested in emergency traumatic work the responsibility of the emegency room on a voluntary basis, and then to set up a rotation system. Ordinarily the assignment should be for one week periods if there is a house staff, or for 24 hour periods if no residents are available. A similar voluntary rotation system should be arranged for medical emergencies. A list of consultants for each of the subspecialties should be posted; in hospitals with surgical privileges clearly defined, its utilization is mandatory.

Emergency room procedures

If the emergency patient has a private physician on the staff of the hospital, of course, there must be immediate notification and cooperation with that physician. Adherence to this principle of medical ethics is often a cause of delay and of consternation to the patient. His personal physician, however, is his guarantee of personal care. Of course, if the situation does not require immediate attention and the personal physician is busy with other patients elsewhere, there naturally will be a delay for further definitive therapy other than first aid which nurses and house staff provide.

Definite restrictions should be placed upon the extensiveness of the procedures in the emergency room. As a matter of fact, all procedures that require other than local anesthesia should be carried out in the operating room.

If the hospital has a recovery room which is used as an intensive treatment center, it may be best to take seriously ill patients directly to this center, where equal or better facilities are available, and thus not congest the emergency room. When a number of critical cases are being

brought in, some facility such as a recovery room must be utilized as part of a mass casualty plan which every hospital should have worked out as part of its disaster plan.

Administrative difficulties

It is important that every hospital have an emergency room. The public looks upon the hospital as a place to turn for immediate medical attention. Since service is expected, there is great difficulty in operating on a business-like basis. Patients and their families feel insulted if any mention is made of financial arrangements, and yet great expense must be met in maintaining the physical and functional organization of the room. If seriously ill patients require blood and other biologicals as well as utilization of expensive equipment, bills can mount rapidly, leaving the administrator hopelessly frustrated in his attempts to prevent serious financial losses. The problem is often accentuated by the doctors who expect emergency room care for their patients without thought of expense. The police and press often emotionalize the situation, thus compounding the problem. In large cities indigent patients can be sent on to the city or county hospital, but the transport may be dangerous to the patient and such transfers often create ill will and bad publicity. In this day of auto accidents, with liability and legal complications, both the doctor and the hospital are subjected to long waits for their remuneration and considerable annoyance with the medical reports.

For the present it seems that we must face the problem by setting up the best facility possible, staffing it ethically and as ably as possible, continuing to remain at the demands of the public, the press, police and others, and praying that it will avoid bad publicity and serious financial loss.

Cancer therapy

More than 55 years experience with irradiation has amply demonstrated that it can destroy cancer of the cervix limited to the pelvis and can permit the patient to pursue a normal, active, and useful life. In contrast to other malignancies, cancer of the cervix tends to remain within the pelvis. It is usually moderately sensitive to irradiation. Small amounts of therapy to limited zones will rarely afford control. Excessive amounts may destroy the maliginancy, but injuries to the patient's vital pelvic structures may be as serious as the tumor. With generally accepted levels of therapy between these two extremes only an approximate 10 per cent of the cases should prove to have resistant malignancy. Less than 10 per cent should experience severe injuries. *G. C. Lewis, Jr., M.D. Radiation Therapy for Cervical Cancer. J. Missouri M.A. May 1960.*

The Coming Bond Plans

Gov. William G. Stratton

The following is excerpted from an address by Gov. William G. Stratton, delivered at a dinner meeting of the St. Clair County Medical Society, September 1 in Belleville.

I want to discuss with you an issue of vital importance to our state today, a practical issue, not a theoretical one: the two bond plans which will be voted on in November in conjunction with the general election.

As you are well aware, one would provide a working fund of $150,000,000 for the construction and rehabilitation of our mental hospital and welfare institution capital plant. The other is for $195,000,000 to construct sorely needed new college buildings at our six state-supported institutions of higher learning.

Both are needed badly, and groups of dedicated citizens such as this can play an immeasurably important role in their adoption.

I hope you will consider well the arguments pro and con, and that you will agree with me that this financing is vital to the welfare of our state.

Mental and welfare institutions bonds

It is true, I know, that in the last eight years we have been able to open two new mental hospitals, the first in thirty years, and have nearly completed a new pediatric institute for retarded children, the first such construction in eighty-two years. Also, we have the money available and plans are on the boards for a similar institution here in southern Illinois.

These constructions have been and are being accomplished out of current funds, but they will be woefully inadequate of filling the needs. Our physical plant for the care of the mentally ill, the blind, the hard of hearing, and the other wards of the state under the welfare department is literally a century old in many areas. In addition, many are dangerous, and a majority are inadequate not only from the standpoint of facility, but from the standpoint of space. We have been able to increase our discharge rate from the mental hospitals some 28 per cent in the last eight years, and we have cut down crowding; but we are still far overpopulated. Even the two new institutions for the mentally retarded will leave a long waiting list of the unfortunate in that tragic category, and at least three other, smaller, institutions are planned to help that situation.

But we need not only new buildings; we need to replace many that now stand. We need to remove the dread of fire; we must replace the wooden floors, the shabby staircases; and we must do it now.

We cannot be blamed for lack of foresight in the past, nor can those who set the standards in the past be blamed too strongly for failing to see the immensity of the problems that burgeoning populations bring. But we can be blamed if we fail to act now—and I mean to act quickly, not set a plan for the next twenty years, but build now for the present and the future.

Actually, if this program had been activated say thirty years ago, difference in the cost of building then as compared with the cost of building now would have been enough less to pay for, and more than pay for, the interest on the bonds in that time. Let me remind you that the cost of the tremendous toll road program we

activated through private bonding rose more than $40,000,000 in the short time we were fighting the crippling court cases which were put in the way of the highly successful toll road plan.

Thus I believe that this method of financing is not only practical from the standpoint of getting a job done when it has to be done. I believe it will save money in the long run.

The university bonds

The same arguments prevail for the university bond issue. It is true that more than 100 college and university buildings have been dedicated in my term of office, but we are still far short of the structures we need, not for the next generation of students but for the present generation. You are all men and women who have acquired education far beyond that obtained by most of our citizens, because your profession requires that extensive training. Thus you know the importance of higher education in a world that is highly competitive and constantly presents new problems.

The simple fact is that as we graduate more and more youths from high school through greater populations, as more and more youths seek a college education, and as more and more are able to afford that education, we are standing virtually still in building to handle the requirement.

Here again it is not a problem of a long range program. It is a problem for today and tomorrow. We must build now to provide the education our nation needs to maintain its status in a world that is at best not too friendly to us.

I don't know of a more important subject for your study and consideration than this bond building plan. It hope we may have your support.

[Ed. note. The Illinois State Medical Society, through action of the Council, has endorsed the $150,000,000 bond issue for new construction and major repairs in existing facilities in mental hospitals and welfare institutions. A request for endorsement of the second bond issue has never been presented to the Society.]

Play and umpire, both?

There is a place for government in medicine. It is the place of the government to govern, to decide the rules under which the game shall be played. It is not the place of the government to make the rules, play the game, and umpire all at the same time—while at the same time making people pay, most often excessively, for participating in the spectacle. Doctors must practice medicine because that is their job. They know how to practice much better than economists, legislators, or politicians. No system yet devised for entrance of government in medicine will work or satisfy the people unless physicians find it workable and capable of permitting satisfactory service. *L. E. Likes, M.D. Socialized Medicine . . . Its Un-American Philosophy. Rocky Mountain M. J. May* 1960.

The physician in community affairs

There have been sad but unmistakable signs in recent years that our time-honored prestige has been weathering badly the storm of public opinion on this issue [participation in community affairs]. Our ivory tower of professional detachment has been called "an ivory tower papered with greenbacks." Members of the medical profession have been characterized as "a hard insoluble mass in the community; all they do is take—they don't want to put anything back." An editorial has baldly stated, "A city needs all the help it can get and doctors should give a little more than just what comes from the business end of a hypodermic." *E. L. Dessen, M.D. The Physician's Responsibility in Community Affairs. Philadelphia Med. April* 1, 1960.

EDITORIALS

Common cold remedies

Remedies for the common cold may be classified in several ways. Some remedies work and some don't; most are in the latter group. Some remedies purport to prevent or cure colds and some to alleviate them; actually there are no real preventives or cures. A third classification consists of remedies that are advertised to physicians and those that are advertised to the laity; in this case, too, most are in the latter group.

But before we consider the various remedies or purported remedies, let us first define a common cold. Present information leads us to believe that the common cold is a group of infections caused by a number of antigenically different but closely-related viruses. These diseases have in common the fact that the incubation period is short—from one to four days—and the symptoms are predominately coryzal, accompanied by a scratchy throat and cough, sometimes by malaise or headache, and only occasionally by fever. The cold itself lasts from three to six days—longer only if complications develop.

At present there are no means of preventing or cutting short a cold. Various vitamins, ultraviolet light, and bacterial vaccines have been strongly advocated at some time in the past, but all have been discredited by carefully controlled experiments. Hope springing eternal in the human breast as it does, many persons (including some doctors) may become convinced of the effectiveness of a new remedy because the patient who seeks a prophylactic measure is the one who has had more than the average number of colds. Since by the laws of chance he is likely to have an average number of colds in the following year, any measure that he takes for the purpose of prophylaxis is likely to be followed by a smaller number of colds than the year before. The patient (and the doctor, too, if he is not careful) is likely to fall into the fallacy of "post hoc, ergo propter hoc."

The idea that a bacterial vaccine might prevent colds was revived recently by Doctor Ritchie of England,[1] but his work has not been confirmed,[2] and there is no reason to believe that his bacterial vaccine is any more effective than any of the dozens that have been tried unsuccessfully in the past.

I do not mean to brush aside the idea that a vaccine will eventually be made that will prevent colds. Indeed, I think this is now a very good possibility, and one might even be available to the practicing physician within the next five years. Recent studies on human volunteers[3] have shown that one attack of an experimental cold apparently conveys good immunity against successive attacks. The isolation of a number of viruses (Hemadsorption, Echo and Reo viruses) which have caused syndromes characteristic of the common cold makes it likely that a sufficient number will soon be available for incorporation into a vaccine that will prevent a substantial proportion of colds.

If the prophylaxis of colds is a possibility for the future only, what of their amelioration? This, too, is a graveyard of remedies. Because of the resemblance of colds to allergic rhinitis, antihistaminic agents have been advocated and widely advertised. Again, as soon as double-blind control studies were done, the antihistaminics were shown to be worthless in upper respiratory infections.[4] Because of the turgescence of the nasal mucous membranes in the common cold, ephedrine-like drugs have been used locally. While these may give temporary relief, the writer has found that they make some patients worse because of the secondary vasodilation that follows the vasoconstriction thirty minutes to two hours after the application. Corticosteroids also have been advocated, but even if they are effective (and this is doubtful), their use is like driving a tack with a sledgehammer—and the risks are comparable.

Until we can devise a specific prophylactic measure, we should stick with aspirin and phenacetin for pain, if any is present; hot irrigations or gargles for sore throat—and above all, warmth. Grandmother had something when she put our feet in hot water. In the course of our experiments on chilling in relation to the common cold, my associates and I found that, when we exposed to cold air any part of the body of a patient with a cold, his nasal and post-nasal secretions increased, and he usually began to sneeze. On the other hand, if all parts of the body except his face and hands remained completely protected, the patient's secretions usually stopped and the turgescence of his nasal mucous membranes decreased. As in so many cases, the simplest remedies are the best.

Harry F. Dowling, M.D.

REFERENCES

1. Ritchie, J. M.: Autogenous Vaccine in Prophylaxis of the Common Cold, Lancet, 1:615-618 (Mar. 22) 1958.
2. Miller, D. L., McDonald, J. C., Williams, R. E. O., and Wilson, J. S.: A Trial of Bacterial Vaccines for the Common Cold in the Royal Air Force, Lancet, 1:358-360 (Feb. 13) 1960.
3. Jackson, G. G., and Dowling, H. F.: Transmission of the Common Cold to Volunteers under Controlled Conditions. IV. Specific Immunity to the Common Cold, J. Clin. Invest., 38:762-769 (May) 1959.
4. Feller, A. E., Badger, C. F., Hodges, R. G., Jordan, W. S., Jr., Rammelkamp, C. H., Jr., and Dingle, J. H.: The Failure of Antihistaminic Drugs to Prevent or Cure the Common Cold and Undifferentiated Respiratory Diseases, New England J. Med., 242:737-744 (May 11) 1950.

Psoriasis — *some newer developments*

"What's new in psoriasis?" is the question that is constantly asked of dermatologists, not alone by patients with the disease but by physicians as well. It has been so since antiquity, and in earliest recorded medical history, psoriasis has always been the subject of a tremendous amount of study directed chiefly to the various clinical aspects of the disease and to the psoriatic patient. Throughout the years despite all efforts, no way was found to identify psoriasis with certainty by chemical examination of the blood or by any other biologic tests of any organ or tissue. Nor were there chemical or physiological determinants to explain the mode of inheritance.

In recent years a fresh approach with new methods of investigation has dominated the research in psoriasis, all of it, as in other branches of medicine, aimed at fundamental or basic-science aspects of the disease. Emphasis currently is on the lesion itself. Biochemical studies have shown that the psoriatic lesion exhibits a marked reduction in the amount of water-soluble polypeptides, and that it is deficient in dipeptidase activity, both conditions seemingly defects in the enzyme systems concerned with protein metabolism of the psoriatic lesion. Specifically, physical abnormalities in the psoriatic layer were reported to include decreased permeability of pulverized scales and a decreased water-binding ability. The chemical anomalies found were low water-extractable free amino nitrogen content and a high sulfhydryl concentration. All of the defects were in the soluble fraction of the horny layer; the insoluble epidermal keratin showed normal values.

These chemical abnormalities offered promise of a working theory to explain the pathogenesis of the disease. Unfortunately, the finding of deficient activity of proteolytic enzymes could not be confirmed by European authors. However, increases in other important water-soluble components of psoriatic scales (pentoses, proteins and mucopolysaccharides) have been reported and the findings confirmed so that the histochemical approach to the understanding of psoriasis is still a hopeful one.

Studies by ultracentrifugation of lesions gave results that would indicate that the immediate cause for the development of the lesions is a disturbance of lipoid metabolism mainly of hydrophobic ones and most likely of cholesterol. This is not to imply that the disturbed lipoid metabolism represents the only and first cause of psoriasis—it may represent either one of the pathogenetic factors, or their result.

Most recently, in an interesting report awaiting publication, the dermatologic group at Stanford University made observations that suggested an autoimmune mechanism in the development of psoriasis. Utilizing the highly sensitive passive cutaneous anaphylactic (PCA) reaction, they demonstrated that the sera of most psoriatic patients contain a substance which, when injected into the skin of experimental animals, reacts significantly when psoriatic plaque homogenate is later administered intravenously. Based on the results of suitably controlled studies, the reaction appeared to be a specific one and different from that seen in a typical passive cutaneous

anaphylactic response. Thus the door is opened a bit to the speculation that the development of psoriasis may depend upon an autoimmune mechanism, although objective evidence for this is still lacking.

Herbert Rattner, M.D.

Nicotinic acid lowers cholesterol

Nicotinic acid is one method for lowering an elevated blood cholesterol level. Large amounts (3 Gm. daily in divided doses after meals) are necessary, and a good response can be expected in 75 per cent of patients. The reduction is most notable in the beta-lipoprotein fraction. The higher the cholesterol level the greater the fall, but it is difficult to lower the level below normal, regardless of dosage. To the best of our knowledge, nicotinic acid alters an enzyme system in the liver that helps in the synthesis of cholesterol.

How long can the body tolerate large doses of nicotinic acid? Side reactions such as cutaneous flush and pruritus are not serious and usually disappear in two weeks. Gastrointestinal irrritation is more distressful and occurs in 40 per cent; peptic ulcers are reactivated after extended usage. A buffered preparation gives relief of symptoms, but it is more logical to try other antiatherogenic agents.

The possible toxic metabolic effects after long usage have not yet been thoroughly explored. The liver is of greatest concern to many authorities even though the evidence to date is scanty that its function is being impaired.

Most important consideration: What does it do to atherosclerosis? We may find in treating this lesion that lowering the blood cholesterol with nonspecific remedies is as foolish as was lowering the blood sugar via diet in the treatment of diabetes before insulin was discovered.

Bowel obstruction by intestinal adhesions

Connolly and Smith[1] suggest intubation, suction, and supportive therapy as the initial approach to bowel obstruction due to intestinal adhesions. This is followed by surgery when prompt results do not occur.

To avoid recurrence, they suggest the careful cleansing of gloves, avoidance of unnecessary trauma, and absolute asepsis. The adhesions are divided by coagulating cautery, and small defects in the peritoneum are covered by grafts of mesothelium from omentum or mesentery. Large defects are let alone. Hyaluronidase is instilled before the abdomen is closed.

Many ways have been proposed to prevent recurrent adhesions. These include the introduction of many solutions into the peritoneum such as saline, glucose, amniotic fluid, and enzymes. None have been too successful. The same can be said of adrenal steroids, heparin, and prostigmine. One of the most unusual proposals was the feeding of an iron suspension by mouth and then moving a magnet over the abdomen postoperatively.

There is no substitute for good surgical technique in preventing adhesions. Trauma to the peritoneal surface stems from rough handling of tissues, improper use of retractors, excessive packing with gauze, especially dry gauze, unnecessary sponging, mass ligatures, as well as large needles, sutures, and hemostats. Gloves contaminated with powder also irritate the delicate membranes. Bacterial contamination and chemical or thermal irritation should be added to the list of etiological features.

[1]Connolly, J. E., and Smith, J. W.: Intestinal Adhesions. California Medicine 92:397 (June) 1960.

Square pegs in round holes

Many Americans have developed a champagne appetite for medical care on a salary that is kept at beer levels through inflation and taxation. They are demanding more hospital benefits, wonder drugs, tranquilizers, and surgery but are unwilling to pay the costs. They also want specialists and demand consultation — not with any but with the leading specialists.

We recognize that the demand stems from the belief that health and good medical care is the right of every citizen. So is good food, clothing, housing, and transportation. In many instances these demands were created by politicians in need of votes and by do-gooders who have the same reason but a more subtle approach.

But the finest medical care is not always the most expensive. It is nice to have a Cadillac, but

a Ford or Chevy does just as well. None of these cars is foolproof, and trouble with the brakes, transmission, and tires occurs independent of the initial cost.

Good medical care can be had at a reasonable price by honest, well informed physicians. Specialists are not always needed, and most illnesses can be treated at home or in the office with less expensive remedies.

The public demand for specialists has challenged the medical student and young physician to excel in a particular field. Throughout the United States there are now eight specialists to every nine general practitioners. In California 60 per cent of the physicians are specialists. The reason why specialists charge more is well known. Many internists for example, conduct a family type practice at a fee in keeping with specialized training. In many instances the conditions being treated, such as simple respiratory infections, do not warrant such talent.

In time the pendulum may swing toward the general practitioner who is capable of treating the majority of patients. The more practical M.D. will be able to minimize the cost without endangering the life of the patient. The trend will mean a return to a more intimate doctor-patient relationship.

Is America interested in health?

It is a strange paradox that the American people are intensely interested in their health, yet they spend more money on smoking and drinking than on drugs, hospitals, and physicians combined. In addition, they complain about the cost of medical care but are willing, if not anxious, to spend comparable amounts on their socially pleasant poisons—tobacco and alcohol.

The latest statistics from the U.S. Department of Commerce showed that in 1959 we spent the following in *millions*:

Tobacco	$7,034	
Alcoholic beverages	9,600	
Total		$16,634
Drugs	$3,604	
Physicians	4,588	
Privately controlled hospitals and sanitariums	4,689	
Medical care and hospital care insurance	1,318	
Ophthalmic products and orthopedic appliances	1,185	
Total		$15,384

But this is only part of the story: Americans spent nearly as much money getting their cars repaired and cleaned ($4,536,000,000) as they did on keeping themselves in running condition ($4,588,000,000). They spent slightly less on shoes ($4,282,000,000). Almost twice as much money went into jewelry and watches as into eye glasses, contact lenses, and orthopedic appliances.

Our democracy is a pressure government, and this year particularly, the pressure is on to pass legislation to expand government medicine. Those who propose to do this appeal to the masses by offering tax-supported medical care, maintaining that it now is too expensive and should be made available to all. Nothing is said about free poisons, shoes for the kids, and government-supported auto repair shops. Somewhere along the line Americans have lost their sense of values. They are willing to "louse up" a profession dedicated to their health and welfare in order to have money left over for habits that have never proved to benefit a single person.

AT THE EDITOR'S DESK



Dermoplasty for Epistaxis

Saunders has reported on a unique operation for the permanent control of epistaxis caused by hereditary hemorrhagic telangiectasia. The mucosa of the anterior third of the nasal septum is removed and replaced with a skin graft. In this way the major source of bleeding is eliminated even though telangiectasia is present in all parts of the nose. This is the area that is subject to trauma and most likely to bleed. Septal dermoplasty was done on eight patients, and all have been able to maintain their hemoglobin values at normal levels for the first time in years.

Oral Polio Vaccine in 1961

According to Dr. L. E. Burney, Surgeon General, Public Health Service, the live poliovirus vaccine is more appropriate for use in a community than on an individual basis. As a result, attention should be given to such matters as administration to special groups, e.g., very young children, pregnant women, susceptible adults.

The live poliovirus vaccine is unique with its capacity to spread the virus in a limited manner to nonvaccinated persons. There is always a possibility of reversion to virulence of live poliovirus vaccine strains, which is an important feature in the community if the vaccine is used improperly. It is for this reason that it has been employed largely in mass administrations where most of the susceptible were simultaneously given the vaccine, thus permitting little opportunity for serial human transmission. It has been administered also during a season of the year when wild strains have shown a limited capacity for spread.

Dr. Burney does not anticipate that the vaccine will be available in any quantity for several months, possibly not until mid-1961.

Pharmaceuticals

Upjohn's new topical steriod base is said to be a substance "very much like human skin oils." The new vehicle, Veriderm, is a happy medium between the waxy extreme of cream bases and the greasy extreme of ointment bases. It remains soft and pliable after application and does not become hard and waxy. It does not feel greasy and replaces natural lipids instead of substituting material derived from sheep and petroleum.

It was developed after large quantities of human skin lipids were studied to determine whether they were stable, similar in all parts of the body and whether there were variations among people and from season to season.

New products containing Veriderm are Medrol-Veriderm and Neo-Medrol Veriderm.

Camoprim® is Parke Davis & Company's new antimalarial preparation that is effective against all stages of the disease. It is a combination of Camoquin (amodiaquin), which destroys the organism in the blood, and promaquine, that destroys the tissue forms as well as certain merozoites that reinfect the mosquito.

Vick Chemical Company has made such highly successful inroads into the ethical pharmaceutical business that it is changing its corporate name. It will be known as Richardson-Merrell, Inc. The new name combines the founders of Vick and the William S. Merrell Company. Their number one product for the moment is MER-29, an anticholesterol drug, which could grow into a $20 million-a-year pill.

Phosphorized Cancer Cells

Cancer cells take up more phosphorus than do normal cells. A team from the Memorial Sloan-Kettering Cancer Center were able to detect a

difference among noncancerous, precancerous, and cancerous lesions of the vulva with intravenous infusions of radioactive phosphorus. In a series of 13 women, certain invasive cancers took up 2.4 to 6.9 times as much phosphorus as normal tissues. Localized cancers took up 1.9 to 3.0, and leukoplakia from 1.5 to 2.4 times normal. Measurements are made from one to three hours after the material is injected with a small hand-held Geiger counter. It usually takes from 30 to 45 minutes. All diagnoses were confirmed by microscopic examination. The method is particularly valuable in determining the extent of the tissue to be removed because, in many instances, the malignant cells extended beyond the visibly affected tissue.

Polls

Medical Times magazine conducted a poll on whether the phrase *socialistic medicine* was more descriptive than the commonly used term *socialized medicine* relative to governmental activities in the practice of medicine. The interviews were made on Madison Avenue and at Union Square in New York. More than half declared themselves in favor of some form of socialized medicine, but only 32.4 per cent at Madison Avenue and 40.5 per cent at Union Square were in favor of socialistic medicine.

Perhaps the medical profession will do well by calling government medicine by the name that describes it the best. Let's make it socialistic medicine hereafter.

Meanwhile Medical Times conducted a presidential poll among 15,000 physicians, residents and interns. Nixon was the choice of 68.6 per cent, Kennedy 25.7 per cent, and 5.7 per cent were undecided. Nixon polled a clear majority in all areas but was strongest in the Rocky Mountain states, whereas Kennedy's maximum strength showed up among the physicians in New England and Middle Atlantic regions.

Hospitalization Reflects Inflation

The cost of hospitalization will more than likely rise even though attempts are being made to cover operating costs, simplify drug inventories, and redesign wards. One authoritative forecast claims that costs will rise 50 per cent in the 10 year period that began in 1958. The most important item is labor, according to the Wall Street Journal. The payroll represents 65 per cent of the total cost. A 10 per cent wage increase is a 6.5 per cent over-all cost rise. We can expect these increases considering the low salaries that many hospital employees receive today.

Hospital equipment costs more. A typical bed now costs $205 as compared with $165 five years ago. A dozen sheets was $19 and now is $25. Microscopes, test tubes, and other laboratory equipment are higher. Many hospitals are going into automation. They now have a $3,500 automatic blood cell counter, a new item on the market.

New York Hospital saves $250,000 to $500,000 a year by buying large quantities and stocking medicine by generic names. Some hospitals are banding together for the joint purchase of supplies. Management audits and new designs are helping also to keep the price of hospitalization from getting out of hand.

Notes from International Congress

Many interesting reports appeared from the third International Congress of Physical Therapy.

Correcting the Hemiplegic Gait. Dr. W. T. Liberson of Hines Hospital told of an automatically administered electrical stimulation that successfully eliminated the "drag and shuffle" gait of hemiplegic patients. The switch is placed in the heel of the patient's shoe. When the foot is off the floor, the current goes on to stimulate the paralyzed muscle. The electricity comes from a portable transistorized stimulator worn around the waist. It is the same type of stimulus used by therapists to prevent muscle atrophy and to maintain nerve fiber vitality.

The method is contraindicated when there is pain, spasm, and difficulty in producing coordination.

Joint Stereo. Dr. Herbert Fischer from the Chicago Rehabilitation Institute told of the value of auscultation in the diagnosis of various knee conditions. According to Dr. Fischer, the normal knee joints produce sounds which are relatively uniform in intensity, frequency, and patterns. In rheumatoid knee joints, a low thud is frequently heard, whereas in degenerative joint disease, the characteristic sound is a series of high frequency bursts at irregular intervals.

The sounds are obtained by conneeting a sensitive microphone to the knee with a rubber ball and recording them on a magnetic tape and later displayed for study on an oscilloscope.

Dr. Fischer may at last have the answer to that oldie: "Do joint mice squeal?"

It was interesting to learn that . . . .

Brazil's first department of physical medicine was organized at the University of Sao Paulo in 1946, and in 1949 a Brazilian physician joined the department.

Blind persons are trained as physical therapists in England.

Hot baths are a popular form of therapy for hypertension in Japan.

House Dust Analyzed

What is the allergen in house dust to which so many allergic individuals are sensitive? This is not known, but the chemical components were analyzed with this in mind by scientists of the California Institute of Technology. They pooled samples of house dust collected from vacuum cleaners and mattress dust; a purified polysaccharide fraction was obtained that produced positive skin reactions in most dust-sensitive allergic individuals.

The material contained a mixture of 95 per cent polysaccharide fraction and 5 per cent polypeptides. It is believed that these isolated sugars and peptides are degeneration products which are broken down by oxidation through bacterial or mold action.

Arthritis "Remedies"

The Arthritis and Rheumatism Foundation has sent out another warning on the menace of misrepresented arthritis remedies. According to the director of the foundation, the latest products to be advertised can match those exploited in the past in extent and ingenuity of their claims. Many are "outright quackery," whereas others contain salicylates built up as a superior product.

Many arthritic patients place great faith in worthless products; but when no relief comes, they become suspicious of all proffered help, even authentic medical care. This is reflected in the attitudes of these people as obtained through surveys conducted by many foundation chapters. Nearly 50 per cent of the arthritic victims are without medical supervision because they believe that little or nothing can be done for them. Every physician should cooperate by bringing this multimillion dollar exploitation to the attention of these patients.

Cost of Polio Vaccine

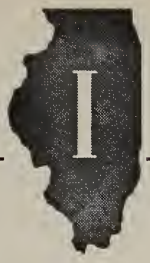
Wyeth Laboratories had this to say about the manufacture of the new Sabin oral vaccine. "Maybe the process will be cheap someday, but it certainly is not going to be cheap initially. Some reports have been published that the Sabin vaccine may cost as little as one tenth that of the Salk vaccine. Our guess is that, initially, it may cost about the same as the Salk vaccine.

"We are talking about a living virus that must be produced with meticulous care to insure the utmost safety."

Diabetes insipidus

Seven patients with diabetes insipidus, including one with the congenital, nephrogenic type, have been treated with drugs of the chlorothiazide series. All have responded with a prompt reduction in the amount of fluid taken voluntarily and in the quantity of urine passed, and body hydration has remained normal. Urinary osmolality has been approximately doubled so that, for the group as a whole, the renal water requirement has fallen by 47 per cent. The drugs have been shown to augment the influence of vasopressin and to permit a considerable though subnormal dilution of urine in response to overhydration. Continued treatment appears not to cause sustained sodium deficit, hypotension or reduction in glomerular filtration rate though potassium deficieney occurs unless an appropriate dietary supplement is ingested. *D. Crawford, M.D., et al. Clinical Results of Treatment of Diabetes Insipidus with Drugs of the Chlorothiazide Series. New England J. Med. April 14, 1960.*

ANNOUNCEMENTS



Annual meeting American Academy of Pediatrics

An extensive five-day program has been planned for the annual meeting of the American Academy of Pediatrics at the Palmer House, Chicago, October 15-20. Ten seminars, each for two full days, are being held on the 15th and 16th, and general sessions will be held 17-20. In addition to individual papers, many symposia and panel discussions are scheduled for the general sessions. These include "Current Concepts of Cell Organization," "Surgical Emergencies of the Newborn," "Basic Concepts in Hypersensitivity," "Antibacterial Agents," "Pathogenesis of Hemolytic Anemias," and "Radiation Hazards." Round-table discussions, a motion picture program, and section meetings on allergy, cardiology, child development, diseases of the chest, and surgery complete the program. The annual banquet will be held Wednesday.

First Percival Bailey lecture

On Monday, October 24, the first Percival Bailey Lecture will be given by Dr. Lauretta Bender, professor of clinical psychiatry, Columbia University, New York. Her subject will be "The Brain and Child Behavior." The lecture will begin at 8 p.m. in the auditorium of the Illinois State Psychiatric Institute, 1601 West Taylor Street, Chicago. Any interested person will be welcome.

The lecture is sponsored by the Professor Percival Bailey Educational Project.

New divisions in PHS state services

Four new divisions in the Bureau of State Services of the Public Health Service have been made as a first step in reorganization "to deal more efficiently with the major public health problems of the next decade." They are Division of Air Pollution, Division of Occupational Health, Division of Nursing, and Division of Dental Public Health and Resources.

Section meeting on eye and ear

The Section of Ophthalmology and Otolaryngology of the Southern Medical Association will have its annual meeting in St. Louis, October 31 to November 3. A live, color telecast on "Preventive and Curative Treatment of Retinal Detachment" will open the program. For further information address the secretary, Dr. A. C. Esposito, Suite 1212, First Huntington National Bank Building, Huntington 1, W. Va.

Course in general surgery

A two-week intensive review course in general surgery will be presented by the U.S. Section of the International College of Surgeons in cooperation with the Cook County Graduate School of Medicine beginning October 24. This is the annual postgraduate course of the College. The program will be offered under the supervision of the Cook County Hospital surgical staff and will include not only surgical technique but also an intensive review in the basic sciences in relation to clinical surgery. Also available is 20 hours of surgical anatomy on the cadaver. Applications should be addressed to the Registrar, 707 Wood St., Chicago 12.

Symposium on Diabetes

The Chicago Diabetes Association will conduct its fourth annual Symposium on Diabetes at the Offield Auditorium, Passavant Memorial Hospital, 303 East Superior Street, November 11, beginning at 9 a.m. Speakers will include Prof. W. H. J. Butterfield and Dr. Peter H. Wright of Guy's Hospital Medical School, London; Dr. Sidney Goldenberg, St. Louis University School of Medicine; Drs. Ralph A. Reis, James B. Hurd, Marvin Cornblath, Henry T. Ricketts, Frank W. Newell, and Benjamin Spargo of the faculties of Northwestern University Medical School and the University of Chicago. There will be a round-table discussion at the luncheon recess at Abbott Hall.

Registration is free for members of the Chieago Diabetes Assoeiation or the American Diabetes Association and for medieal students and resident house staff members. The fee for nonmembers is $25. Members of the Academy of General Practiee may elaim hour-for-hour credit in Category II. Inquiries may be addressed to The Chieago Diabetes Assoeiation, 620 N. Miehigan Ave., Chieago 11.

PG courses on disease of the chest

Two postgraduate eourses on diseases of the chest have been arranged by Couneil on Postgraduate Medical Education of the Ameriean College of Chest Physieians. "Clinical Cardiopulmonary Physiology," under the eo-chairmanship of Dr. Albert H. Andrews of the University of Illinois College of Medieine and Dr. Edwin R. Levine of the Chieago Medieal School, will be held at the Sheraton Towers Hotel, Chieago, October 24-28.

The seeond eourse, "Recent Advanees in the Diagnosis and Treatment of Diseases of the Heart and Lungs," with Dr. Edgar Mayer, New York University Postgraduate Medieal Center, and Dr. Alfred S. Dooneief, Columbia University College of Physicians and Surgeons, and Dr. Emil A. Naclerio, Harlem and Columbus hospitals, New York, as co-ehairmen, will take plaee at the Park Sheraton Hotel, New York, November 14-18.

Tuition for eaeh five-day course will be $100, ineluding round-table luneheon diseussions. Additional information may be obtained by writing to the Director, Ameriean College of Chest Physieians, 112 E. Chestnut St., Chieago 11.

Seminar cruise

The Duke University Medical Sehool is sponsoring a postgraduate Medieal Seminar Cruise to the West Indies this fall aboard the new *Kungsholm,* Sweden's largest transatlantic liner. The luxury ship, whieh will sail from New York on November 9, will visit the Virgin Islands and San Juan, Puerto Rico, and will return to New York on November 18. Rates begin at $230.

Shipboard leetures on various subjeets in medicine, pediatries, and surgery will be given by the following members of the Duke Medieal School faculty: Dr. Edwin P. Alyea, urology; Dr. Doris Ahlee Howell, pediatrics and pediatric hematology; Dr. Elbert L. Persons, medicine; Dr. William M. Shingleton, surgery; and Dr. William M. Nicholson, medieine.

The program will provide 20 hours of eredit toward postgraduate requirements of the Ameriean Aeademy of General Praetice. While designed primarily for the generalist, the program should be of value and interest to the speeialist as well. Informal panel discussions, elinicopathologic conferenees, and formal presentations will be given by members of the faeulty.

Physicians from Illinois are invited to join the eruise. For further information write to the Direetor of Postgraduate Medieal Edueation, Duke University Medical Center, Durham, N.C.

OB-GYN district meeting

The annual meeting of District V, the Ameriean College of Obstetricians and Gynecologists will be held November 3-5 at the Deshler Hilton Hotel in Columbus, Ohio. The preliminary program lists six panel diseussions: "Surgieal Complications of Gyneeology," "Toxemia of Pregnaney, Current Studies," "Prevention of Perinatal Mortality," "Surgieal Management of Cervieal Careinoma," "Clinieal Correlations and Timing of Ovulation," and "Glucose Tolerance Test In Pregnancy." A series of 15 breakfast eonferenees will be held on Friday.

Patients for NIH cancer studies

The cooperation of physieians is requested in studies on colon and rectal careinoma reeently initiated at the Clinieal Center, National Institutes of Health, Bethesda, Md. Encouraging results in the treatment of gastrointestinal careinoma have been reported using the pyrimidine analogues 5-fluorouracil and 5-fluorodeoxyuridine. However, other reports have raised the question of their effeetiveness.

The Chemotherapy Serviee of the National Caneer Institute is conducting studies of these agents in careinoma of the colon and rectum in order to better define their place in the treatment of metastatic gastrointestinal neoplasm. The side effects of these agents may be eonsiderable, so patients must be in good general condition in order to tolerate adequate doses. Also the presence of tumor masses whieh can be either measured direetly or demonstrated on roentgen films is neeessary in order to determine the antitumor effeet of the drugs in short trial periods.

Patients can be accepted for these studies if they are ambulatory, have normal leukocyte count, renal and hepatic function and if they have metastases in the lung, peripheral lymph nodes (such as supravicular or cervical) or skin.

Referrals of such patients will be greatly appreciated. Physicians who wish to have their patients considered for study at the National Cancer Institute may write or call Dr. Clyde O. Brindley or Dr. Paul P. Carbone, National Cancer Institute, Bethesda 14, Md. (OLiver 6-4000, Ext. 4251).

Research in urology award

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years, and to hospital internes and residents doing research work in urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Biltmore, Los Angeles, May 22-25, 1961.

For full particulars write to William P. Didusch, Executive Secretary, 1120 North Charles St., Baltimore, Md. Essays must be in his hands before Dec. 1, 1960.

Papers for thoracic society

The American Thoracic Society (formerly, American Trudeau Society) is soliciting abstracts of papers on all scientific aspects of tuberculosis and nontuberculous respiratory diseases for presentation at its annual meeting in Cincinnati, May 22-24, 1961. Abstracts must be in the hands of the program committee not later than Jan. 7, 1961. Rules governing the submission of abstracts may be obtained by writing Leon H. Schmidt, Ph.D., Chairman, Medical Sessions Committee, American Thoracic Society, 1790 Broadway, New York 19.

Public health traineeships

The Public Health Service awarded 622 public health traineeships amounting to $2 million during the fiscal year that ended June 20, 1960. Of this number, 377 were awarded through grants to schools, and 245 were awarded directly to trainees.

The traineeships went to doctors, nurses, dentists, nutritionists, sanitary engineers, veterinarians, and other public health workers in all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

The program provides for graduate study in schools of public health or other colleges and universities. Persons trained under the program will work in the field of public health, chiefly in state and local health departments.

Since the program was started in 1956, more than 2,300 persons have received traineeships. Most of the trainees had had little or no prior public health training or experience.

Booklet on immunization for travel

To help answer the questions for people traveling in foreign countries, the U. S. Public Health Service has issued a booklet, "Immunization Information for International Travel," revised May 1960. It is available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 25¢ a copy.

Use Journal placard—Vote

As a contribution to the over-all activity aimed at stimulating physicians to vote, the Illinois Medical Journal has published on page .... of this issue a placard that can be used November 8 to inform patients that their doctor has closed his office briefly to enable him to vote.

Recognizing the great issues at stake in the coming elections, the medical profession has hurled itself into the political arena with surprising gusto. Throughout the state there is a sweeping interest in getting people to the polls to express themselves on the various issues of concern to medicine.

The Journal page has been perforated so that it can be removed easily. Just insert the hours you will be away from your office and place the placard where your patients will see it.

November clinics for crippled children

Nov. 1—Pittsfield, Illini Hospital
Nov. 2—Fairfield, Fairfield Memorial Hospital
Nov. 2—Hinsdale, Hinsdale Sanitarium
Nov. 3—Macomb, St. Francis Hospital
Nov. 4—Chicago Heights (Cardiac), St. James Hospital

Nov. 8—East St. Louis, St. Mary's Hospital
Nov. 8—Peoria, Children's Hospital
Nov. 9—Champaign-Urbana, McKinley Hospital
Nov. 9—Joliet, Silver Cross Hospital
Nov. 10—DuQuoin, Marshall-Browning Hospital
Nov. 10—Springfield, St. John's Hospital
Nov. 10—Sterling, Community General Hospital
Nov. 15—Alton, Alton Memorial Hospital
Nov. 16—Evergreen Park, Little Company of Mary Hospital
Nov. 16—Springfield p.m. (Cerebral Palsy), Memorial Hospital
Nov. 17—Decatur, Decatur-Macon County Hospital
Nov. 17—Elmhurst (Cardiac), Memorial Hospital of Du Page County
Nov. 17—Rockford, St. Anthony's Hospital
Nov. 22—Effingham (Rheumatic Fever), St. Anthony Hospital
Nov. 22—Peoria, Children's Hospital
Nov. 23—Aurora, Copley Memorial Hospital
Nov. 30—Rock Island (Cerebral Palsy), Foss Home, 3808—8th Avenue

National Foundation fellowships for postdoctoral study

Postdoctoral fellowships are offered by the National Foundation to candidates for training in research, orthopedics, preventive medicine, arthritis and related diseases, and rehabilitation. The closing date for submitting applications to be reviewed in February is November 1.

Postdoctoral research fellowships are awarded to applicants with an M.D., a Ph.D., or equivalent degree for basic or advanced training in laboratory research in medicine and the related biological and physical sciences. This program is *not* intended for experienced investigators who need support for a research project.

Postdoctoral clinical fellowships are available for study of arthritis and related diseases, orthopedics, preventive medicine, and rehabilitation.

Financial support varies according to education, professional experience, marital status, and number of dependents, but the minimum is $1,500 a year with $540 allowed annually for each dependent. Annual increases of $480 are ordinarily granted. For a full academic program, complete tuition and fees are paid; for other programs, a sum not exceeding $1,250 a year is made available to the institution. Transportation not exceeding $600 will be paid for research and orthopedic fellows if foreign study is approved.

All awards are made upon recommendation of the appropriate National Foundation Fellowship committee. U. S. Citizenship is required, but those who have filed a petition for naturalization will be considered. Fellowships are ordinarily awarded for a minimum of one year and may be renewed upon approval of the committee.

Rheumatic fever less severe

A comparison of the severity of rheumatic fever in the past four decades from the long term studies at the House of the Good Samaritan in Boston is presented. The most striking features have been: a modest decline in the incidence of cardiac involvement in terms of residual murmurs, from 75 per cent in 1921-22 to 60 per cent in 1950-51; a twofold amelioration in the degree of carditis as indicated by heart size; and an eightfold reduction in mortality rate. *E. F. Bland, M.D. Declining Severity of Rheumatic Fever: A Comparative Study of the Past Four Decades. New England J. Med. March 24, 1960.*

NEWS of the STATE



County

Adams

County Medical Society Sponsors Exhibit. "Physician Interest in Education at the High School Level," is the title of an exhibit to be shown by Dr. Harold Swanberg, Quincy, at the AMA Clinical Meeting in Washington, D. C., November 28-December 1. The exhibit is a project of the Society for Academic Achievement, of which Dr. Swanberg is secretary, and the Adams County Medical Society, one of the sponsors since 1957. The organization is carrying on an international (United States and Canada) basis what the local medical society and Kiwanis Club carried out on a county basis. The SAA is dedicated to promote, popularize, and reward high academic scholarship achievement in the high schools and to motivate talented students to seek a college education. The county program has been lauded by the AMA in J.A.M.A. and the PR Doctor on several occasions. The public relations benefits to the profession, especially in these times of crises, are obvious.

The ISMS Council has approved submitting a resolution to the AMA House of Delegates suggesting that state medical societies urge their component county societies to carry on programs similar to those in Adams County.

Cook

Elected. Dr. Lindon Seed was made president elect and Dr. William Hutson a trustee at the recent meeting of the Society of Nuclear Medicine. Both physicians are from Chicago.

Carlson Memorial Lecture. A memorial lecture fund in honor of the late Dr. Anton J. Carlson, chairman of the department of physiology at the University of Chicago, is being set up by his friends, under the chairmanship of Dwight J. Ingle, Ph.D., present chairman of the department. Dr. Carlson was Frank P. Hixon Distinguished Service Professor and contributed much in the areas of medicine, science, and industry. The fund appeal is being extended to individuals and groups who might welcome the opportunity to honor Dr. Carlson through the university he served.

Annual Dinner. The Chicago Medical Society honored its outgoing president, Dr. George Turner, at the annual dinner October 5 at the Furniture Club of America. Dr. Karl Meyer presided. Dinner dancing and a musical comic interlude made up the program.

At the end of the dinner, Dr. Turner presented the gavel to Dr. T. R. Van Dellen, the incoming president.

Conference on V.D. "V.D. Boomerang—Everyone's Concern" will be the theme of a conference to be held in Chicago on November 16 in the Conrad Hilton Hotel from 12 noon to 4:30 p.m. Organized by Dr. Samuel L. Andelman, Chicago Commissioner of Health, the conference is being sponsored by the Chicago Association of Commerce and Industry, the Illinois Department of Public Health, the Chicago Board of Health, and the Illinois Social Hygiene League.

Its purpose is to call attention to the large increase throughout the country in reported cases of syphilis and gonorrhea. Chicago's growing population, the increase in seaway port facilities, air transportation, and migrant workers as well as the changes in teen-age behavior have all contributed to the increase of venereal disease. To guard against its spread, the assistance of all Chicagoans is needed.

Heads Hospital. Mr. Gavin A. Pitt has been elected president and chief executive officer of Presbyterian-St. Luke's Hospital effective September 19. For the past three years, Mr. Pitt has been vice president of the Johns Hopkins University and the John Hopkins Hospital in Baltimore.

History of Pathology Lectures. A series of six informal lectures, "The History of Pathology," will be given by Dr. Lester S. King, clinical professor of pathology, in the University of Illinois College of Medicine each Wednesday beginning October 5, from 12:00 to 1:00 p.m., in room 419 of the medical building, 1853 W. Polk St.

While Dr. King has published in the fields of anatomy, neuropathology, and general and experimental pathology, he has lately devoted himself to the philosophical and historical aspects of medicine. He is the author of "The Medical World of the Eighteenth Century" (University of Chicago Press, 1958) and many journal articles on the history of medicine and philosophy of science.

Hospital Receives APA Certificate. Forest Hospital of Des Plaines, a 90-bed unit devoted to care and treatment of mental and emotional illness, has received a certificate showing full approval from the Central Inspection Board of the American Psychiatric Association. The hospital is one of only 53 in the United States to be given such approval.

Traveler. Dr. John A. D. Cooper, professor of biochemistry and associate dean of the Northwestern University Medical School, Chicago, spent two weeks as a visiting scientist at the Puerto Rico Nuclear Center in San Juan. He gave seminars on the application of radioisotope techniques in medicine, and consulted with the clinical division on general operation of the center.

He also represented Northwestern at a three-day faculty conference on medical education at the University of Kansas, where he outlined for the group the new six-year medical school plan recently announced.

Madison

Dr. Roger F. Sondag of Springfield, Deputy Director of the State of Illinois Department of Public Health, was a guest speaker at the Madison County Medical Society's September meeting in Edwardsville. He spoke on "A Health Department for Madison County," a subject which has been under discussion there.

Montgomery

The Montgomery County Medical Society has elected Dr. J. R. Rebillot, Litchfield, as president and Dr. M. J. Hantover, Hillsboro, secretary.

St. Clair

The St. Clair County Medical Society has a local Diabetes Committee. President Louis Kappel, M.D., appointed Dr. Wayne Cox of East St. Louis as local chairman, to be assisted by Dr. John Coffey of Belleville and Dr. Joseph Petrikas of East St. Louis.

General

Federal cancer training grants awarded

The University of Illinois College of Medicine and Loyola University Stritch School of Medicine are among medical centers and teaching hospitals who received grants July 1 from the U.S. Public Health Service for advanced training of physicians in diagnosis and treatment of cancer. The schools have selected individuals to be trained and will administer the grants. Under this clinical traineeship program established in 1937, more than 200 physicians in 80 institutions are currently being trained.

Dr. Youmans joins AMA staff

Illinois physicians will welcome the return to this state of Dr. John B. Youmans, who from 1946-1949 was dean and professor of medicine at the University of Illinois College of Medicine. Dr. Youmans assumed duties as director of the division of scientific activities of the American Medical Association October 1, succeeding the late Dr. Edward L. Turner. He has been technical director of research for the U. S. Army Medical Research and Development Command.

Medical news on TV this fall

A 15-minute weekly review of medical news for physicians, "This Week in Medicine," using regular commercial television channels, will go on the air Sunday afternoons beginning October 30 over a nationwide network.

The selection of the broadcast time was based on preferences expressed by physicians in cities where the program was tested with the cooperation of county medical societies. Tests in Dallas, Kansas City, Miami, and Binghamton showed that, though seen by the public over regular channels, the technical language and subject matter limited the audience to physicians and members of allied health professions.

Recorded on video tape and film, each program will include a world-wide summary of medical news and a filmed feature on some aspect of research, clinical medicine, or surgery. It will summarize highlights of major scientific meetings and will call attention of physicians to important editorial content of scientific journals. It will mark the first use of regular television channels to reach a nationwide medical audience on a professional level.

The series will be sponsored by CIBA Pharmaceutical Products Inc., gathered by its network of contributing editors and correspondents, and produced by the editorial staff and medical consultants of Medical News. Content will be controlled by the editorial staff and medical consultants independent of the pharmaceutical company.

Clinical indications for use of CIBA drugs will not be cited, but will be made available to physicians through normal channels. Nonprescription drugs will not be mentioned.

Medical societies will be furnished information on stations and broadcast time, and specialized organizations and societies will be given advance information on scheduling of filmed features of special interest to their members.

Physicians appointed to board for the handicapped

Gov. W. G. Stratton has announced six appointments to the 15 member Advisory Board for the Care and Education of Physically Handicapped Children. The board is advisory to the Illinois Children's Hospital-School, Chicago, an institution under supervision of the Illinois Department of Public Welfare.

New members are Dr. L. L. Fatherree, director of the Illinois Department of Public Health; Oliver P. Kolstoe, professor and chairman, department of special education, Southern Illinois University, Carbondale; Dr. Kilian Fritsch, Belleville, orthopedist. Dr. Fatherree will fill the unexpired term of the late Dr. Roland R. Cross, former state public health director.

Dr. Meyer A. Perlstein, Chicago, was reappointed.

The Illinois Children's Hospital-School, created in 1945, serves educable children and youths between the ages of 5 and 21. Eligibility is confined to Illinois residents afflicted with orthopedic of neurologic handicaps so severe that they cannot take proper advantage of community educational facilities. It endeavors to provide for each student an educational program suited to his needs, physical rehabilitation, and social guidance.

Grant for Zoonoses Laboratory

The University of Illinois has received state funds of $170,000 for construction of a Zoonoses Laboratory. The National Institutes of Health previously approved a grant of $128,100 to supplement the state funds.

The building will contain 14 isolation units where research on animals with communicable diseases will be carried on by the College of Veterinary Medicine. The university recently established a Center for Zoonoses Research, reportedly the first in the United States and the second one in the world.

Appointed medical examiner

Dr. William Johnson, Galesburg, has been appointed to the Medical Examining Committee in the Department of Registration and Education. He succeeds Dr. Edwin S. Hamilton of Kankakee, who has resigned.

Dr. Johnson is a medical director of the Galesburg Clinic, past president of the Illinois Surgical Society and of the Illinois Chapter of American College of Surgeons. He is secretary and past regional vice president of the American Fracture Society and is serving as a member of the credentials committee of the American College of Surgeons and the International College of Surgeons.

Dr. Hamilton has served on the committee for many years and helped bring about many improvements in the Medical Practice Act, such as increased penalties for illegal practice, injunctive enforcement of the Medical Practice Act, and citizenship requirements.

Study TB facilities

The Public Health Service, in cooperation with the American Hospital Association and the National Tuberculosis Association in August appointed a six-member ad hoc committee to study the changing needs in facilities for tuberculous patients.

Primary tasks assigned are (1) to analyze and review data on the incidence and prevalence of tuberculosis and the recent trends in the use

of tuberculosis beds in order to determine the future need for tuberculosis facilities, and (2) to develop principles to guide states and communities in the construction of new facilities and the conversion of existing facilities no longer needed for the treatment of the tuberculous patient.

Health insured in Illinois

The number of persons in Illinois with health insurance reached a new high of 8,328,000 at the end of 1949, an increase of 89,000 during the year, according to the Health Insurance Institute.

The report was based on the fourteenth annual Health Insurance Council survey which revealed that nearly 128 million Americans, or 72 per cent of the total civilian population, were protected by health insurance as of December 31, 1959.

The number of persons with surgical expense insurance climbed from 7,544,000 at the end of 1958 to 7,772,000 at the end of last year. Persons protected by regular medical expense insurance, which helps pay for doctor visits for non-surgical care, increased from 5,296,000 to 5,629,000.

Districts-Society meetings scheduled

A series of Councilor District meetings are being scheduled for the coming year on request from Mr. Robert L. Richards, executive administrator, to the Councilors of the Society.

Meetings scheduled at press time:

DISTRICT	DATE	PLACE	COUNCILOR
1	Oct. 16	Faust Hotel Rockford	Dr. Clark
11	Oct. 30	Dunlap Hotel Joliet	Dr. Klein
6	Nov. 13	Joliet Hotel Quincy	Dr. Portes

Meetings were held in September and early October for Districts 4, 8, 10, and 2.

Purpose of the meetings is to discuss with officers and members problems of the county societies and the help and services available from the State society afforded through its reorganization. Discussion areas will be selected by the Councilor. Staff directors of the society will attend each meeting: Mr. Richards, Donald L. Martin, public relations and field services; Walter L. Oblinger, legislation and legal counsel; Roger L. White, medical services and economics research; Albert Boeck, publications and scientific activities; Mrs. Frances Zimmer, executive assistant.

Meetings have been well attended.

ELECTION. At the annual meeting of the Illinois Society of Anesthesiologists, the following physicians were elected: Harold L. Harris, Evanston, president; William K. Stephan, Decatur, president elect; Imre A. Illes, Highland Park, vice president; Robert F. Finegan, Elgin, treasurer; and Forrest J. Woodman, Evanston, secretary.

ELECTION. At the annual meeting of the Executive Committee for the Illinois Association of Blood Banks for the coming year are Dr. Donald R. Russ, president; Dr. John Maloney, president elect; Dr. Frank E. Trobaugh, Jr., vice president; Dr. Morris Goldenberg, secretary-treasurer.

Deaths

DANIEL HERBERT ANDERSON*, Chicago, a graduate of Northwestern University Medical School in 1902, died May 2, aged 84. He was on the staff of the Provident Hospital.

THOMAS ADDISON BAIRD*, Chicago, a graduate of Rush Medical College in 1925, died August 17, aged 65. He was house physician for the Sherman and Ambassador hotels.

FRANK CHARLES BECKER, Chicago, a graduate of the Medical College of Indiana in 1896, died June 17, aged 91. He had served on the staffs of the Grant and Alexian Brothers hospitals.

EMIL LAWRENCE BERNARD*, Springfield, a graduate of Northwestern University Medical School in 1909, died June 6, aged 75. He was associated with St. John's Hospital and was a past president of the Sangamon County Medical Society and a veteran of World War I. He was a member of the American Academy of General Practice.

WILLIAM ALVIN BRANDON*, Carbondale, a graduate of the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1908, died June 12, aged 79. He was associated with the Doctors and Holden hospitals.

HERMAN N. BUNDESEN*, Chicago, president of the Chicago Board of Health and dominant in the Chicago Health Department since 1922, died August 25, aged 78. He was born in Berlin,

Germany, but came to Chicago early in life. He worked his way through Northwestern University Medical School, graduating in 1909, interned at the U. S. Army Medical in Washington, and served a short term in the Army specializing in epidemiology. He also held a D.Sc. degree and was certified in Public Health.

As early as 1914 Dr. Bundesen was with the Chicago Board of Health as a part-time employee; from 1922-27 he was health commissioner; from 1928-31 he served as Cook County coroner; and since 1931 he had been president of the board, which until last spring included the duties of the long-vacant post of health commissioner. Various other services he has given Chicago have been regional consultant in contagious disease, U.S. Veterans Bureau, 1927; trustee, 1922, and vice president of the Board of Directors 1947-55, Municipal Tuberculosis Sanitarium; chief, Emergency Medical Service, Chicago Metropolitan Civilian Association, 1942; chairman, Venereal Disease Division, Medical Advisory Board, 1939, and Selective Service System, 1942.

Dr. Bundesen was a militant crusader in matters of public health, undeterred by public and professional criticism. In his drive for better baby care over the years he clamped down on regulations in maternity wards and hospitals, thereby giving Chicago the best record in infant mortality. With the assistance of the U. S. Public Health Service, he set up clinics in Chicago to stamp out venereal disease. He ordered 400,000 tubercular cows slaughtered in a drive for pure milk that undoubtedly contributed to his loss of the Democratic governorship in 1936. Chicago became the most Salk-vaccinated city in the world after the mass Salk vaccine inoculation program to the underprivileged in 1955 and 1956. The city achieved the lowest incidence rate in the nation through the all-out efforts of Dr. Bundesen and his department.

He was known nationally through his syndicated health columns and his book as well as many booklets on baby care.

Dr. Bundesen was a past president of the American Public Health Association, a Fellow of the American College of Physicians, and a member of the Association of Military Surgeons of the United States and the American Association for the Advancement of Science.

Levi A. Burhans*, retired, Peoria, a graduate of Northwestern University Medical School in 1908, died August 9, aged 87. He was on the staff of Proctor Hospital. He served in the Spanish-American War and during World War I held the rank of captain in the Medical Corps of the U.S. Army.

Hugh Irving Conn*, Newman, a graduate of Bennett Medical College in 1915, died June 9, aged 69. He was on the staff of Jarman Hospital in Tuscola, a veteran of World War I, president and member of the school board for many years, and past district governor of Kiwanis International.

Frank Mortimer Dry*, Chicago, a graduate of Loyola University School of Medicine in 1918, died May 23, aged 66. He was on the staff of the Augustana Hospital and from 1928 to 1930 was on the faculty of Northwestern University Medical School. He was a member of the American Academy of General Practice.

Jacob V. Edlin, retired, West Palm Beach, Fla., former superintendent of Chicago State Hospital, died August 19, aged 62. He was a graduate of Tufts University School of Medicine, Boston, in 1922.

Egbert W. Fell*, retired, Rockford, a graduate of Northwestern University Medical School in 1903, died July 16, aged 82. At the time of his death he was psychiatrist for Winnebago Board of Education and the Family Welfare Association, Winnebago County Courts. He served at Medical Lake (Washington) State Hospital, and Boston Psychopathic Hospital. He was chief of the neuro-psychiatric section at Camp Grant Hospital during World War I and also served in the neuro-psychiatric section at Walter Reed Army Hospital. During World War I he was a major in the Medical Corps and in World War II served on the medical advisory board. From 1919 to 1923 he was director of Cincinnati Sanitarium, was at Wilgus Sanitarium, Rockford, until 1932 and practiced privately in Rockford from 1932 to 1950. He was a member of the American Psychiatric Association and an honorary member of the staff of St. Anthony Hospital.

He called himself a "self-appointed botanist," wrote and published "Flora of Winnebago County," and was the author of "Illinois Physician-Botanists" which appeared in the Illinois Medical Journal, and many other articles. He was honorary curator of the Illinois State Museum and Evelyn J. Fernald Memorial herbariums. He

was a member of the Rockford Nature Study Society, the Illinois Audubon Society, the American Society of Plant Taxonomists, and many other groups.

William R. Fletcher*, Joliet, a graduate of Kentucky School of Medicine in 1900, died May 20, aged 83. He was on the staffs of Silver Cross and St. Joseph's hospitals, had been physician and surgeon with the Illinois State Penitentiary for 20 years, and was a past president of the Will-Grundy Counties Medical Society.

William F. Granzig*, Des Plaines and Niles, a graduate of Chicago Medical School in 1939, died August 31, aged 47. He was a member of the staff of Northwest Community Hospital.

Elmer Forrest Herdien*, Watseka, a graduate of Northwestern University Medical School in 1901, died May 27, aged 84. He served on the staff of the Iroquois Hospital, was a member of the American Association of Railway Surgeons, and a veteran of World War I.

Caius M. Lewis*, Bridgeport, a graduate of Physio-Medical College of Indiana in 1898, died July 26, aged 93. He had been very active in civic affairs in his community, serving on the board of education, as mayor of the city, and in many other capacities.

George Martin McBean*, retired, Chicago, a graduate of Hahnemann Medical College and Hospital in 1899, died August 27, aged 85. He had studied in Vienna and London. Dr. McBean was a charter member of the American College of Surgeons.

George Leroy Mossy, Lake Villa, a graduate of Chicago College of Medicine and Surgery in 1915, died May 16, aged 76. He was associated with the Veterans Administration in Downey and was a veteran of World War I.

Wilfred J. Nowlin*, Farmer City, a graduate of the University of Illinois College of Medicine, died August 11, aged 57. He was on the staff of the St. Joseph's and Mennonite hospitals in Bloomington. During World War II he served as an examining officer of Selective Service. He was a member of the American Academy of General Practice.

William R. Pattis*, Chicago, a graduate of Medizinische Fakultat der Universitat, Wien, Austria, in 1920, died August 11, aged 69. He served on the staff of Woodlawn Hospital.

Harry M. Richter*, retired, Chicago, a graduate of the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1894, died August 18, aged 88. After graduation he became a member of the faculty at Northwestern University Medical School, from 1932 to 1937 was chairman of the department of surgery, and was made professor emeritus in 1937. At various times he was on the surgical staffs of Passavant, Michael Reese, Wesley Memorial, and Mount Sinai hospitals. He became a specialist in thyroid surgery and surgery for newborn infants. Dr. Richter was a member of the Western Surgical Association, and a Founding Fellow of the American College of Surgeons.

Robert Harley Smith*, Mahomet, a graduate of the University of Illinois College of Medicine in 1930, died August 1, aged 57. He was a past president of the Burnham City Hospital staff, Champaign, and had been president of the Champaign County Medical Society, and a member of the American College of Surgeons.

James Tully Snider, retired, Mt. Sterling, a graduate of Chicago Medical School in 1923, died August 6, aged 70.

Perry H. Wessel*, Moline, a graduate of State University of Iowa College of Medicine in 1906, died August 2, aged 75. He was one of the pioneers in the use of x-ray and studied under the late Dr. Emil H. Grubbe. Dr. Wessel was on the staff and a past president of the Moline Public Hospital, and a former chairman and member of the executive committee for many years. He was also a staff member of Moline Lutheran Hospital, and St. Anthony's Hospital, Rock Island. He served Moline as city physician from 1912-1919 and during World War I was with the U.S. Medical Corps. He was an emeritus member and Fifty Year Club member of the Illinois State Medical Society, a past president of the Rock Island County Medical Society, and president for three years of the former Moline Physicians Club. Dr. Wessel held memberships in the American Geriatrics Society the International College of Surgeons and the Fifty Year Club of American Medicine.

George E. Wilkinson*, Alton, a graduate of Washington University School of Medicine in 1898, died May 28, aged 91. He served on the staffs of the Alton Memorial and St. Joseph's hospitals.

**Indicates member of Illinois State Medical Society.*

BOOK REVIEWS



French's Index of Differential Diagnosis. Edited by Arthur H. Douthwaite, ed. 8. $24. Pp. 1111. Baltimore, Williams & Wilkins Company, 1960.

French's book on differential diagnosis was first published in 1912. His work was carried on by Arthur H. Douthwaite, M.D., F.R.C.P., after Dr. French's death in 1951. Dr. Douthwaite, as editor, has enlisted the aid of 19 contributors to make possible this eighth edition of French's Index of Differential Diagnosis of Main Symptoms.

The success of this book has rested with its extensive 150 page general index. From here the reader obtains the number of places in the book where each disease is discussed and the symptom is considered. There are 774 illustrations of which 216 are in color. Many of the illustrations are pictures of x-ray films or photographs of patients or pathological specimens.

T. R. Van Dellen, M.D.

Fundamentals of Clinical Hematology. Byrd S. Leavell, M.D., and Oscar A. Thorup, Jr., M.D. $10. Pp. 508. Philadelphia, W. B. Saunders Company, 1960.

This text on hematology, according to the authors, is designed for the beginner in hematology and for the physician in active practice. The authors' intimate familiarity with the field of hematology has led to a comprehensive, yet critical coverage of the subject matter.

A presentation of the morphology, origin, chemistry, and function of blood cells is followed by discussions of the normal physiology of erythropoiesis, leukopoiesis and hemostasis. The interpretation of pathologic states in terms of abnormal physiology are discussed with particular reference to their application in diagnosis and treatment. The discussion of the clinical syndromes is accompanied by short accounts of actual cases which illustrate appropriate points.

Special consideration is given to the diagnosis of patients who present the problems of anemia, hemorrhagic and purpuric states, or lymphadenopathy. The subjects of polycythemia, leukemias, malignant lymphomas, and multiple myeloma are well written, concise and important diagnostic points are emphasized. A separate chapter is devoted to hematologic technics.

The text is illustrated with photographs, photomicrographs, charts, and graphs. The bibliography at the end of each chapter, although not exhaustive, is adequate and up to date. In general, the common hematologic diseases and their diagnoses are emphasized more than the rare conditions. The simple and yet comprehensive descriptions of hematological problems make this textbook excellent for both medical students and clinicians.

Louis R. Limarzi, M.D.

Surgical Errors and Safeguards. Max Thorek. ed. 5. $25. Pp. 652. Philadelphia, J. B. Lippincott Company, 1960.

Having achieved the status of a fifth edition, this volume is now considerably strengthened with chapters by distinguished contributors such as Edward Compere, Paul Szanto, and Harold Voris. It now comes nearer to its underlying purposes to warn and guide the surgeon, to show him where he can go astray, and to indicate where he can apply safeguards to reduce his chance of error.

Ambitious in scope, the book embraces surgical subspecialties as well as general surgery. It even forages into anesthesiology in one of its best chapters by E. A. Rovenstine and V. J. Collins. Included is a section on cardiac surgery by Arthur Vineberg and his collaborators and a section on thoracic surgery by S. A. Mackler. Phillip Thorek contributes the chapter on the esophagus and furnishes the posthumous preface for his father, Max Thorek.

Although admirable and unique in purpose, the book falls disappointingly short of its mark. It needs thorough editing. Its redundancies of text and mistakes such as mislabelling of full page illustrations are inexcusable. Inclusion of a chapter on surgical treatment of peripheral vascular disease is needed if only to remove the section on treatment of varicose veins from the chapter on orthopedic surgery.

A revision of this work away from quantity toward quality should be the direction of the next edition.

John J. Bergan, M.D.

The List Method of Psychotherapy. Elizabeth Sher, et al. $7.50. Pp. 258. New York, Philosophical Library, Inc., 1960.

Various techniques in psychotherapy, some old and others new, are constantly being explored and utilized. The "List Method of Psychotherapy" represents a new technique in the field of psychoanalysis. It begins with the concept of "milieu therapy." Eventually the patient enters this "therapeutic community." His feeling of belonging in it or to it is of tremendous value because he soon learns that the basic principle of the entire method involves the substitution of a "program for a problem." Also therapy does not end in the office of the therapist; the patient is encouraged to seek continuing education. Interestingly enough, a few patients have even chosen the field of psychotherapy after graduation from college.

Six members of Dr. List's school give their comments in as many chapters as the book contains. Typical chapter headings are "Warmth in the Therapeutic Process," and "The Reception Room as Therapeutic Community." Of interest is the fact that every therapist trained by List is a former patient.

Louis D. Boshes, M.D.

Surgery of repair as applied to hand injuries. B. K. Rank, and A. R. Wakefield. ed. 2. $9. Pp. 288. Baltimore, Williams & Wilkins Company, 1960.

For anyone called upon to treat hand injuries this comprehensive yet succinct book, authored by two Australian plastic surgeons, is most highly recommended. In 1953 the first edition was acclaimed throughout America and Great Britain by surgeons whose main interest is surgery of the hand. Although few changes have been made in this second edition, thirty-one illustrations were added, and the text was expanded by 28 pages.

Each of the five parts of this book contains information useful for an experienced surgeon as well as the student, house officer, or general practitioner. Since the material is based upon the authors' experiences, the reader is not confronted with diverse or outmoded methods of management.

Part I contains a concise chapter on surgical anatomy and another on the examination and appraisal of the acutely injured hand. Primary treatment of open injuries is covered thoroughly in the four chapters of Part II.

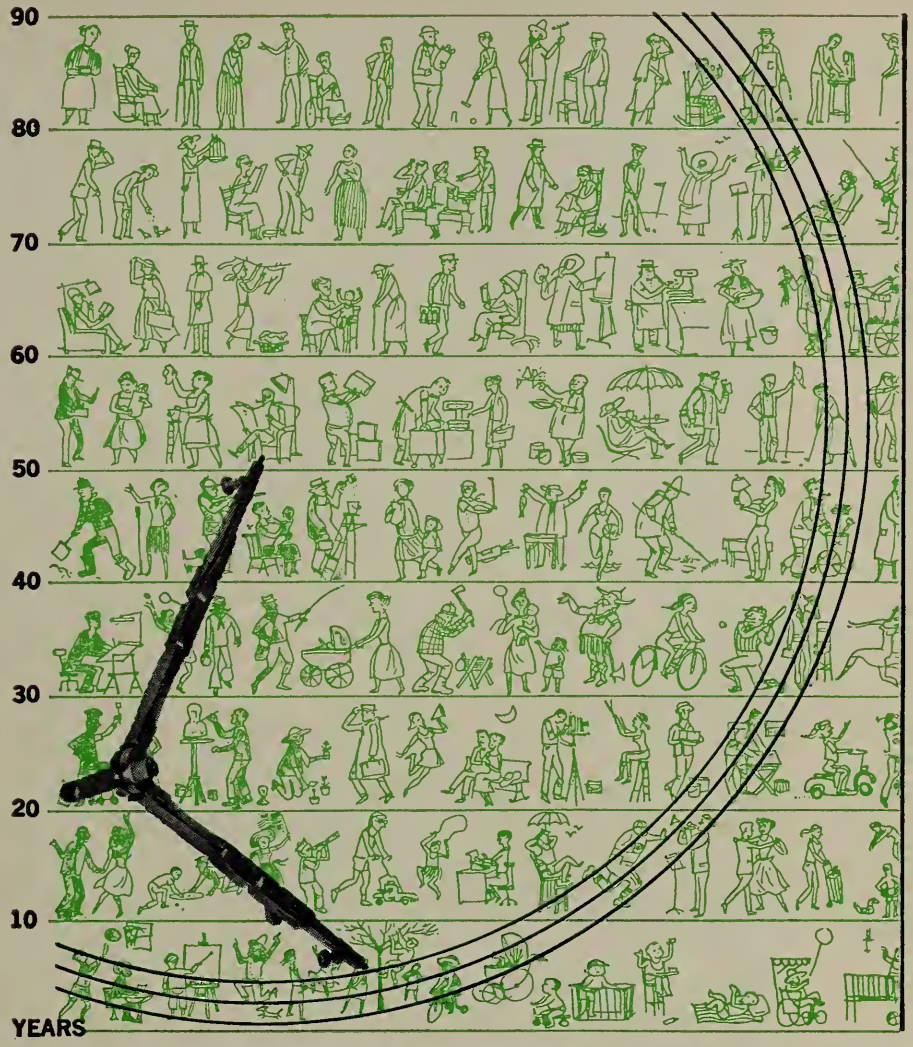
A third part, called "intermediate treatment," is concerned with the management of unhealed wounds, tissue necrosis and granulating wounds. The chapter on re-establishment of joint mobility contains illustrations of various types of dynamic splints which are easily improvised.

Secondary reconstructive procedures are presented in Part IV, which has separate chapters on scar disabilities, tendon and nerve repairs, amputations, and reconstructive procedures for mutilating injuries. The last part is devoted to the treatment of burns, hand injuries in children, and prostheses.

Although the general principles of treatment are the same for all patients, the authors discuss the variants in the management of hand injuries in children. The aspects of preoperative appraisal, operative techniques and after care are presented concisely and with authority.

The text is profusely illustrated with photographs of various types of injuries in diverse phases of treatment and follow-up care. Careful indexing, masterful outlining and conciseness make this book a most practical, ready reference which should be in every hospital library.

John L. Bell, M.D.



senile anxiety
disorientation
agitation
hostility
irritability
apprehension
hysteria
insomnia
chronic urticaria
alcoholism
menopausal syndrome
neuro-dermatoses
functional gastrointestinal disorders
psychoneuroses
tension headaches
dysmenorrhea
psychosomatic complaints
situational stress
asthma
hyperactivity
tics
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Reversing ourselves

Our newspaper brought word the other day that evoked once more a line of thinking which recurs more often as we grow older. It has to do with the many startling reversals of medical dogma that confront the clinician who lingers long on the medical scene. The latest of these is the reported suspicion that whitebread may emerge as the health seeker's choice over wholewheat because strontium-90 has affinity for the hull of the grain and is said to be gathering there in tiny but increasing amounts.

This loosened a flood of memories and made us wonder just how many dogmas of our youth have been replaced or at least challenged by diametrically opposite doctrines. Who could have imagined 30 years ago that the highly lauded "protective foods"—notably butter, cream and eggs—would eventually be under suspicion as the possible source of gummy material to clog our arteries and predispose to coronary thrombosis?

We are old enough to have seen a double cycle of reversal in the surgical treatment of varicose veins from stripping to injections and back to stripping again. We recall that certain heretics have suggested refrigeration of the patient as preferable in the treatment of shock to the time-honored application of external heat. Furthermore, we vividly remember the solemn admonitions of our clinical teachers that bleeding peptic ulcer requires complete deprivation of food; but then came Meulengracht with his bold advice to wipe away the blood from the patient's lips with one hand and stuff food into his mouth with the other.

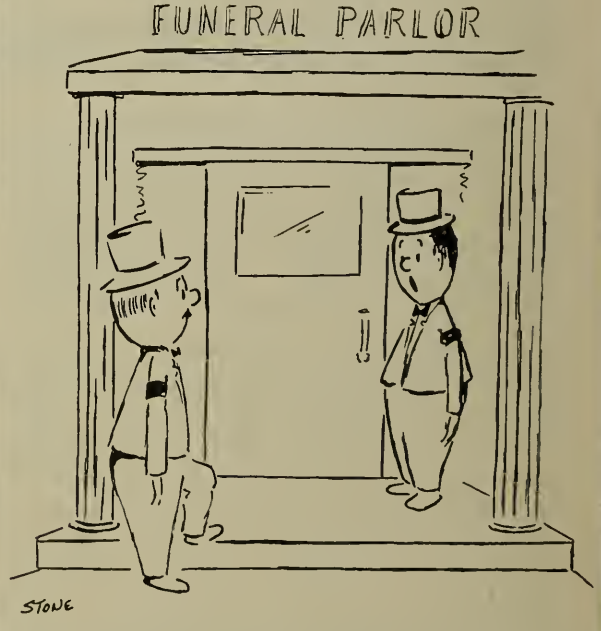
Only yesterday the aging male was cautioned in summer against lawn-mowers and in winter against snow-shovels. Now, however, the sprightly patriarch of cardiology, Dr. Paul D. White, is singing the praises of exercise to ward off heart attacks and urging the "senior citizen" to buy a bicycle.

All this adds up to some confusion but makes the world a livelier place to live in. It also serves to remind us of some of the wisest words ever uttered by a student of disease—words that are never going to be challenged or reversed. The observer was Hippocrates and he said:

"Life is short—The Art is long—Opportunity is fleeting—Experiment is perilous—Decision difficult." Editorial. *R. P. Middleton, M.D. The Reversible Garment Called Truth. Rocky Mountain M. J. Jan.* 1960.



The Medical School wants to use me for final exams.



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Riker

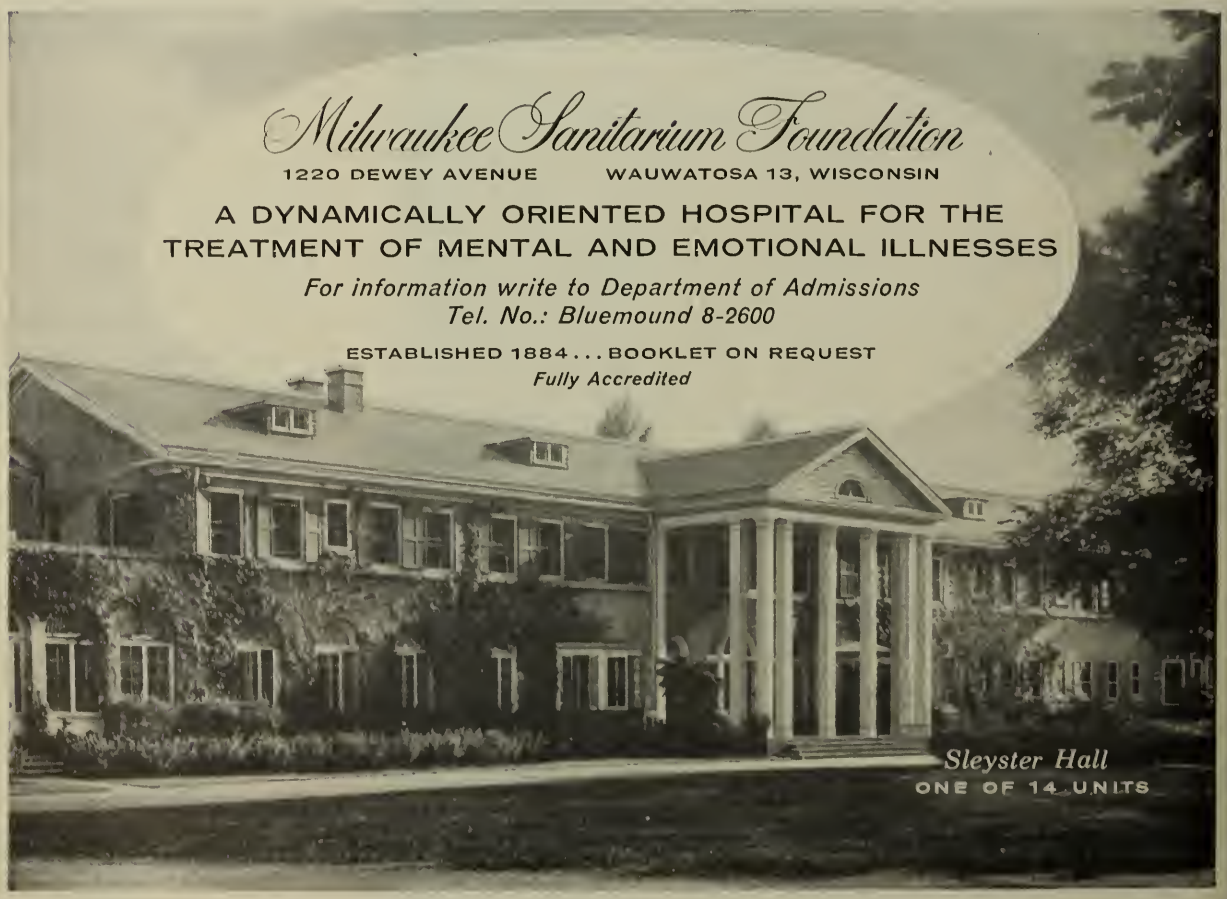
Northridge, California

A way of life

First of all, what is group practice? Dr. Edwin Jordan has called it a way of life, and it seems to me that this is a fundamental and basic concept. Certainly it is more than an arrangement for the convenience of physicians to practice in pleasant and well equipped surroundings. It is more than an economic device to achieve security, stability and evenness of income over one's productive period, although it provides, to an extent, all of these things. Properly conceived, and properly implemented, group practice is, to me, one means by which several physicians can combine their skills their talents—to provide their patients with better medical care. It is a way of practice in which one subscribes to the principle "No One of Us Is as Smart as All of Us," and it is a way of practice which, if it is to be successful, can have but one guiding light, that is, rendering better service to the patient. Let me hasten to say that it is not the only way to practice excellent, effective, ethical, honest, and economically successful medicine—it is simply *one* way of accomplishing it. It is fraught with hazards, as are other methods of practice, and it is no panacea for the problems of the sons of Hippocrates, but it can be a most satisfying, enjoyable, and rewarding way of practicing medicine. *J. W. Annis, M.D. Group Practice. J. Florida M.A. May* 1960.

More blood for smaller twin

A newborn infant would receive from 75 to 100 cc. of blood from the placenta and cord if it were lowered below the level of the placenta after delivery. In case of homologous twin pregnancy, if the firstborn is small, a delay in clamping the cord is advised, so that the fetus receives at least 100 to 150 cc. of blood from the common placenta. If the first child is large and healthy, immediate clamping of the cord is advised, so that the second twin within the uterus may benefit by the extra placental blood after the first delivery. With modification, this method can be followed in cesarean section. A lowered fetal mortality rate for the smaller twin may thus be obtained. *M. Berlind, M.D. The Fate of the Smaller Twin: A Method of Increasing the Survival Rate. J. Internat. Coll. Surgeons. July* 1960.



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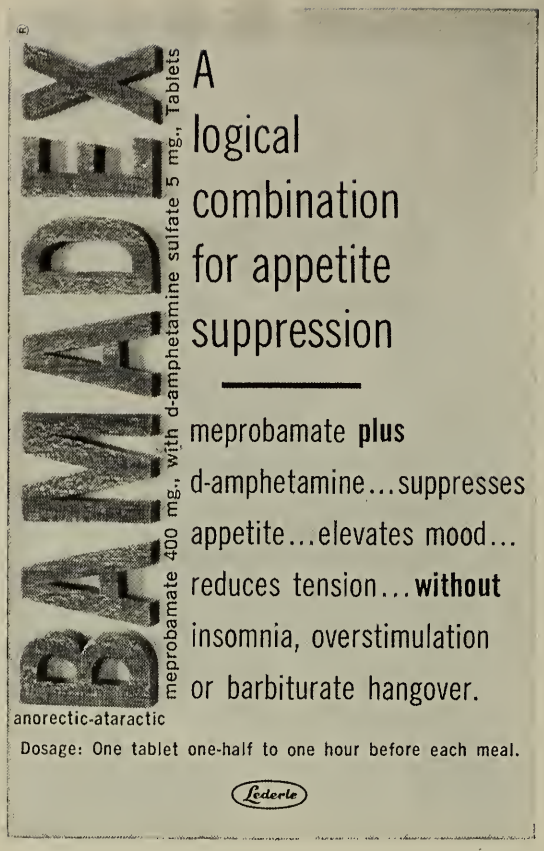
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*Rock, J.; Garcia, C. R., & Pincus, G.: *Am. J. Obst. & Gynec. 79*:758, 1960.

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Nucleic acids—semantic catalyzer

In academic circles the statement is often heard that there are four magic words in modern biology. These are: genetics, immunology, nucleic acids and viruses. Two of them designate organized bodies of knowledge that are divisions of biological science. One identifies molecular substances of large size and known chemical constitution. One names the smallest and most remarkable of infectious agents. It is beginning to appear that all these terms are closely interrelated; that three of them identify biological phenomena, each of which has its origin in the information-bearing capacity of the fourth, nucleic acids.

Genes, the unit of genetics, are now thought to consist of unique nucleotide sequences in the nucleic acid molecule. Immunology is believed to depend on the recognition of differences in chemical structure of substances that are under the control of genes. Viruses are considered to serve as vehicles for the transmission of nucleic acid; to be specialized organelles for the introduction of new genetic material into a cell. One may question whether the time-honored distinctions between genetics, immunology, and virology have not become more methodological and semantic than real. All three areas may now be thought of as dependent on functional manifestations of the informational activity of a single molecular substance, nucleic acid. *Frank L. Horsfall, Jr., M.D. Viral Infection and Viral Disease in Man. Proceedings of the Staff Meetings of The Mayo Clinic. May* 25, 1960.

Ulcers and steroids

During the period in which the patient receives steroid therapy, the chances of developing peptic ulcer are 100 to 130 times greater than for the nonsteroid-treated patient. The only preventive method is the use of prophylactic ulcer regimens with antacids and anticholinergic therapy in patients receiving 10 mg. per day of prednisteroids, or its equivalent. All patients with an ulcer history or those who develop dyspepsia on steroids should be placed on a regular ulcer schedule regardless of steroid or dose employed. *E. L. Dubois, M.D., et al. The Corticosteroid-Induced Peptic Ulcer: A Serial Roentgenological Survey of Patients Receiving High Dosages. Am. J. Gastroenterol. April* 1960.

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Cross section, atherosclerotic artery

to aid in the dietary control of serum cholesterol



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MAZOLA Margarine is indistinguishable from other quality margarines as to taste, aroma and handling characteristics. Thus, it can be part of the regular diet for the whole family, including the hypercholesterolemic patient. The major ingredient in MAZOLA Margarine — liquid MAZOLA Corn Oil—is NOT hydrogenated, thereby preserving its rich content of linoleates.



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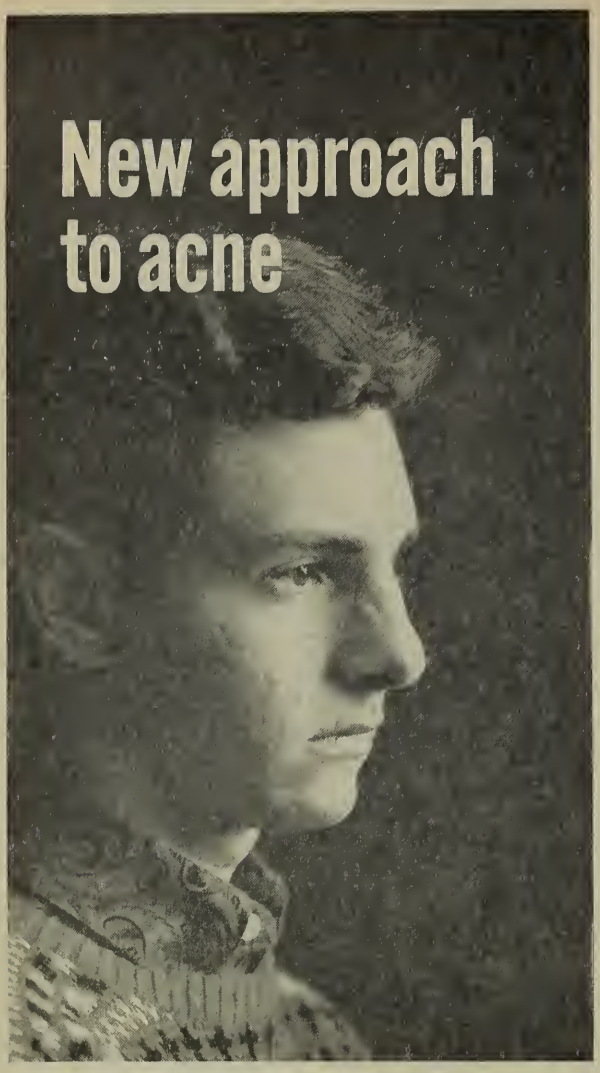
Linoleic acid	12 Gm.
Oleic acid	23 Gm.
Saturated fatty acids	8 Gm.
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Vascular accidents

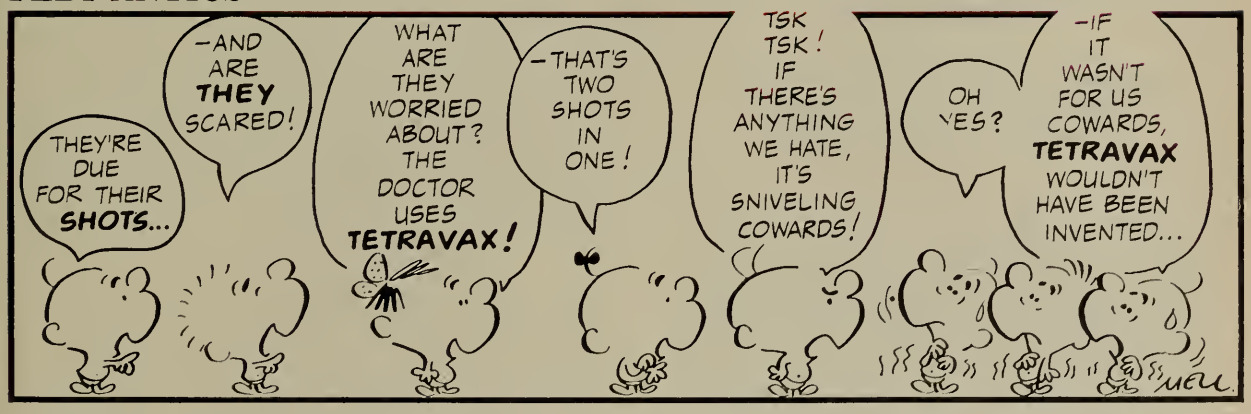
Conceding that there are still families where a grandparent or a great-grandparent fits into the household with ease, it nevertheless is true that care of the aged has become a real problem in many homes. Here is a woman of seventy-seven who has just suffered a stroke that has changed her whole personality. She was a gentle, motherly type, but is destined—thanks to modern medicine—to live another ten years, and it is heartbreaking to hear her snarling at her family. There is a man who had a brilliant mind, but the circulation of blood in his brain is now so imperfect that he cannot remember the days of the week; he is miserable in this condition and takes to alcohol, making great difficulty for everyone around him. Here is an aunty whose eyesight has failed, and whose major skill was sewing; she was normally a considerate, unselfish person, but now becomes so enclosed by dark loneliness that the universe shrinks, and she is at the center of it, demanding constant attention. *Ada Campbell Rose. When You Retire. Presbyterian Life. Sept.* 1, 1960.

I do believe there is many a tear in the heart that never reaches the eyes.—Norman MacEwan

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In the course of these studies, it became apparent that nicotinuric acid might be the active metabolite of nicotinic acid which is responsible for its action in lowering serum cholesterol levels. The data presented here give strong support to this hypothesis. More extensive studies are planned and are necessary to establish the theory. The studies to date have been hampered by the lack of sufficient amounts of nicotinuric acid, and also by the fact that nicotinuric acid is more slowly absorbed than nictinic acid and hence much larger doses must be given to obtain the desired effects. Therapy with nicotinuric acid has marked advantages over administration of nicotinic acid because side effects, flushing and pruritis, were not observed during treatment with nicotinuric acid.

It will be necessary to study the effect of nicotinuric acid on each of the possible mechanisms involved in lowering serum lipid levels to ascertain the focal point of action. *O. N. Miller, Ph.D. Investigation of the Mechanism of Action of Nicotinic Acid on Serum Lipid Levels in Man. Am J. Clin. Nutrition. July-August 1960.*

Circulating bacteria

The ventilation system of a hospital plays a major role in the dissemination of bacteria, as Walter has so ably shown. However, this need not be so if two simple steps are taken. The first is to see that air circulates from clean areas such as operating room suites, nurseries, and patient's rooms, and not from a utility area. The second step is to use bacteriologically effective filters. Mechanical filters are satisfactory provided they are changed as often as once a week. There is some evidence, however, that electrostatic precipitator filters are even more efficient. *E. H. Spaulding, Ph.D. Role of Disinfection Procedures in Control of Hospital Staphylococcal Infections, J. Albert Einstein M. Center, April 1960.*

A man's ideal, like his horizon, is constantly receding from him as he advances toward it.
— *W.G.T. Shedd*

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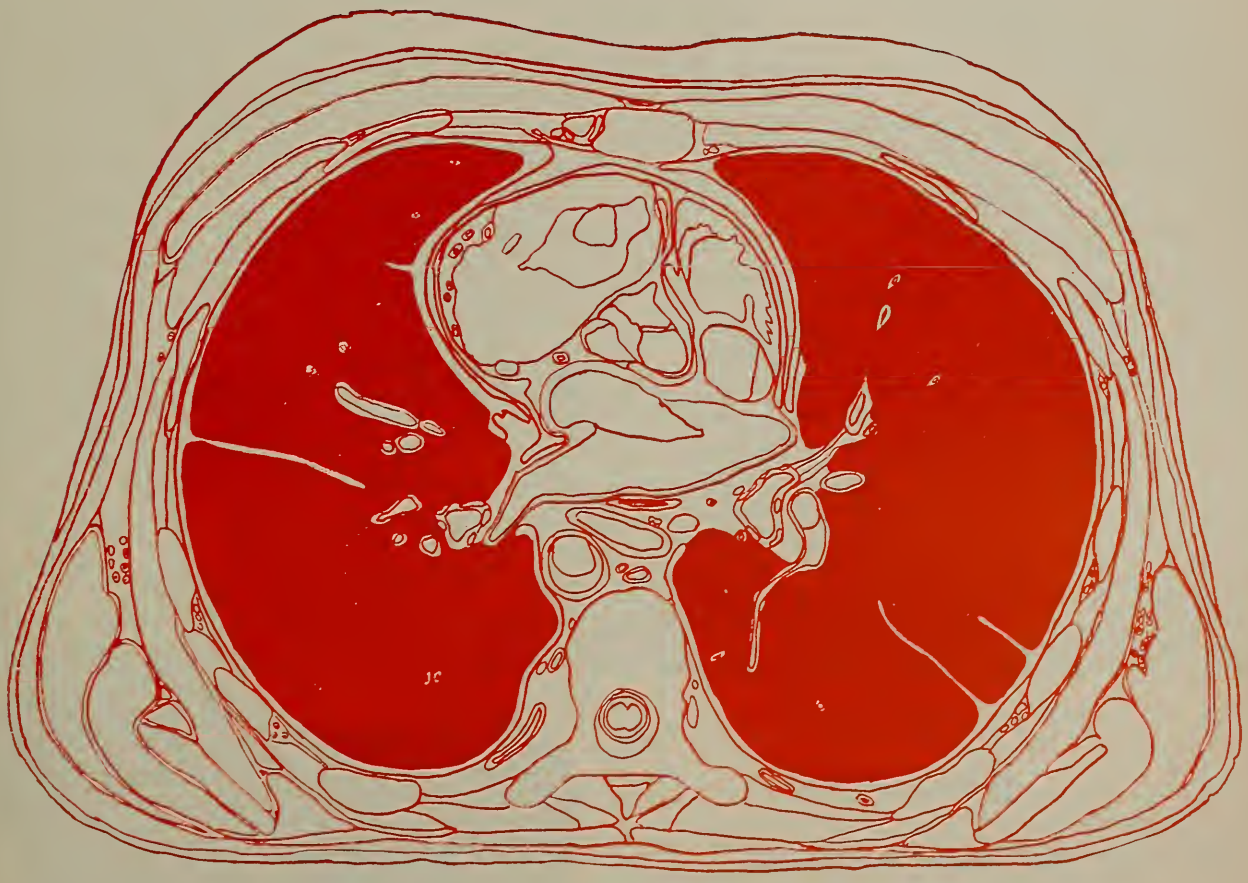
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Most physicians deliberately avoid localizing lesions within the nervous system and, as a result, often feel insecure in their interpretation of neurologic illness. This no doubt is due to the fact that they continue to recall the complex intermixture of fibers and cells that plagued them during their undergraduate courses in neuroanatomy. It is certainly true that the nervous system is by far the most complex of all structures and does consist of a maze of cells and fibers with an inconceivable number of interconnections. However, from the point of view of practical application to clinical medicine, only a very few of these systems are used, and these offer the physician a relatively simple, easily applied approach to the problems presented by his patient. Since localization of lesions within the nervous system is often necessary to determine the nature and extent of a lesion and hence its therapy, it is of advantage to the physician to have some simple guides to such localization. *A. B. Baker, M.D. Cerebral Localization in the Practice of Medicine. J. Lancet. July 1960.*



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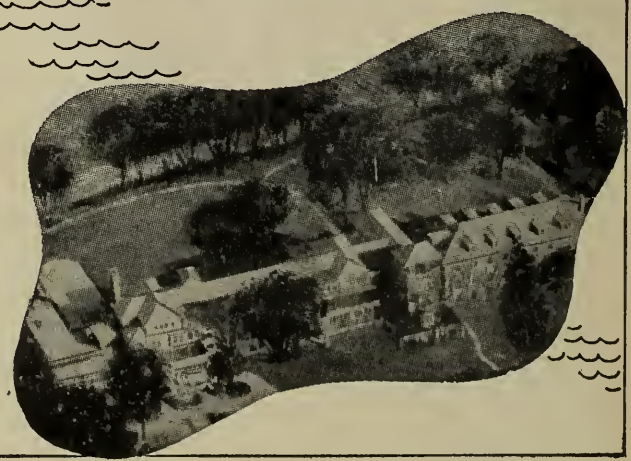
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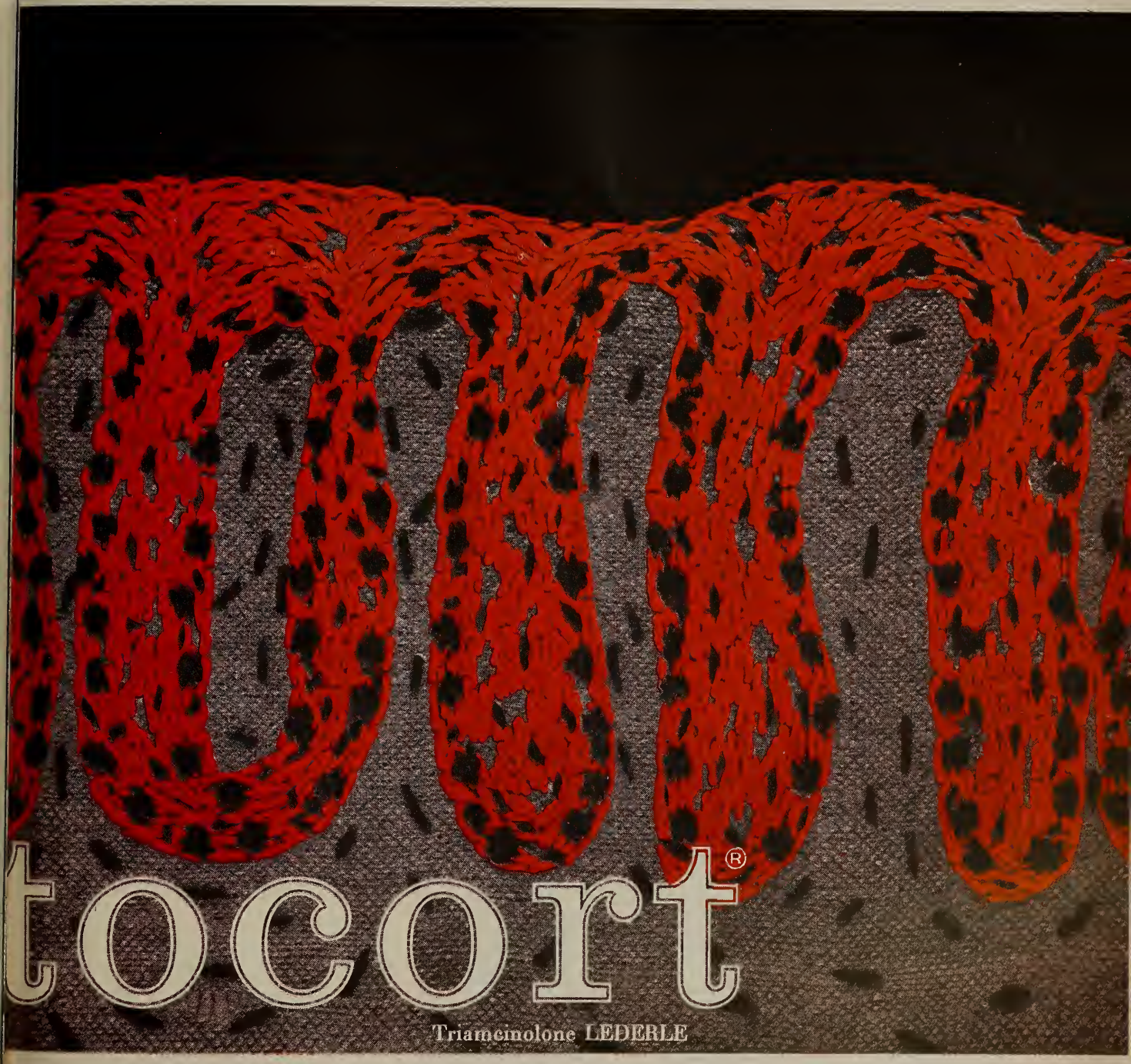
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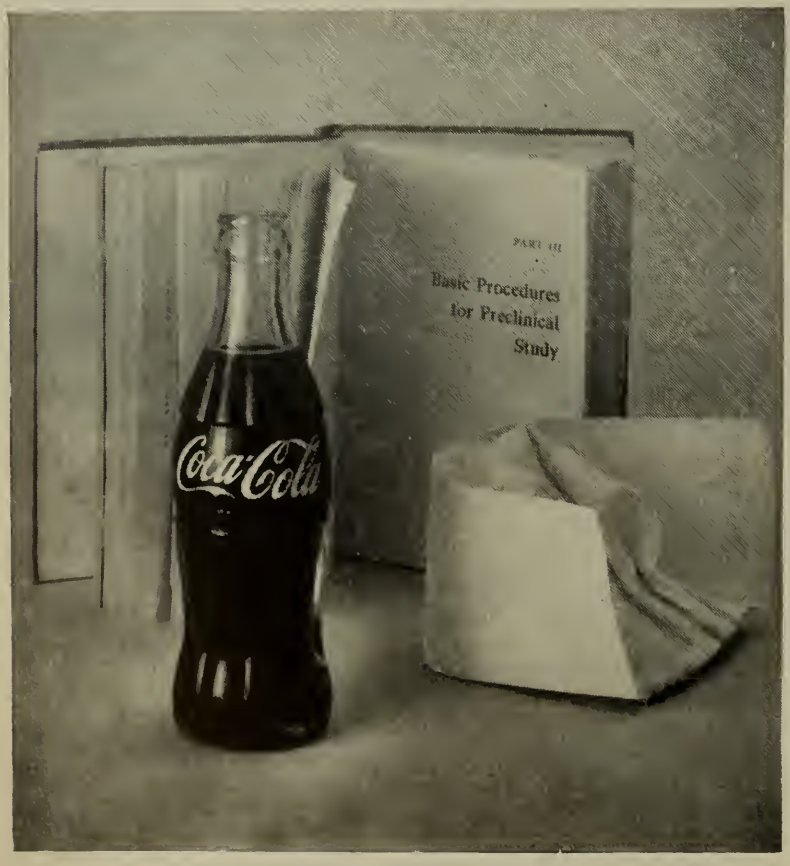
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The use of the ophthalmoscope may be necessary. A patient was struck in the eye by a nailhead. The physician, not a specialist, used a magnifying glass but did not examine with the ophthalmoscope or x-ray. He found a cut in the cornea, removed some rust, and washed the patient's eye. One month later the patient went to an eye specialist with the complaint of diminishing sight. Ophthalmoscopy and x-ray showed a fragment of steel in the eye, and the ophthalmologist operated in an attempt to save the eye. The bulb collapsed and blindness ensued. The patient sued the original physician. The specialist testified that the foreign body, not its removal, caused the blindness and that it is customary to use x-ray and ophthalmoscopy in examining an injured eye. The court found against the defendent physician, held lack of due care in examining the patient. *R. S. Fisher, M.D. Malpractice Actions and Prophylaxis. Maryland M.J. May 1960.*



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One can advise comfortably from a safe port.
— *Schiller*



He was just sitting there. Suddenly he yelled "I've had a spontaneous remission'" Then he left.

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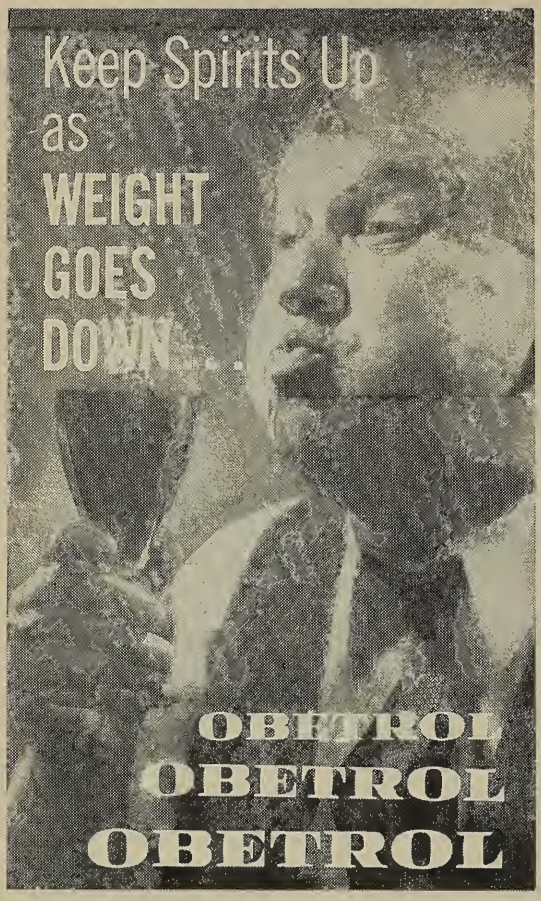
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Old shoppers

One thing we found in a university clinic is that many of the patients that come to us have been "shoppers." They have been to see all kinds of doctors before and usually some doctor along the line has told them that this is their imagination. They are just sitting there waiting for us to repeat it. When we say, "We don't know the explanation; we want to try to take care of you," you can just sort of see them heave a sigh of relief, "This time somebody is going to look at me for a change." *E. L. Bortz, M.D., et al. Panel discussion. Growing Older: The Medical, Mental and Social Problems of the Aged. Delaware M. J. May 1960.*

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"Nice" girls

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You may be deceived if you trust too much, but you will live in torment if you do not trust enough.

— Dr. Frank Crane

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Early, please

If the parents ask you when they should take Susie to the dentist, please tell them at age three. no later. At three, children are old enough to be fairly cooperative with the dentist, and in most cases not too much dental damage will have been done. If they don't ask you, and in looking at their red, swollen tonsils you look past some decaying teeth, please tell them they've got infection in teeth as well as tonsils. Tell them to see their dentist. (And, on the other hand, dentists should send them to the physician when they see those inflamed tonsils.) Certainly a child should never reach the age of six without having been seen by the dentist. By six and a half some already are losing their first permanent molars. *John E. Gilster, D.D.S. Dental Health for Children. Mississippi Valley Med. J. March* 1960.

When you have spoken the word, it reigns over you. When it is unspoken you reign over it. — *Arabian Proverb*

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Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

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References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

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The Month in Washington



Representatives of the medical and health professions, the federal government and national civic groups are cooperating in development of a program for starting the general use of the Sabin live-virus poliomyelitis vaccine next year.

Shortly after clearing the Sabin vaccine for general use, Leroy E. Burney, M.D., Surgeon General of the Public Health Service, asked 23 non-government organizations to designate members to serve on a Surgeon General's Committee on Poliomyelitis Control.

An Agenda Committee met with PHS officials in Atlanta Oct. 11 and 12 and drafted a basic agenda for a meeting of the Control committee in midwinter. At the Atlanta meeting, preliminary consideration also was given to administrative and technical problems involved in use of the live-virus vaccine developed by Albert B. Sabin, M.D., of Cincinnati.

The Sabin vaccine is not expected to be available in substantial quantities before mid-1961.

The chief question is whether the vaccine — which is given orally in the form of pills, liquid or candy — will be administered on individual or mass community basis. The PHS special committee that recommended approval of the oral vaccine said that the community basis would be better.

"Because of the unique nature of live poliovirus vaccine, with its capacity to spread the virus in a limited manner to non-vaccinated persons, the committee cannot make recommendations for manufacture without expressing concern about the manner in which it may be used," the special committee said. "The seriousness of this responsibility can be illustrated, for example, by the known potentiality of reversion to virulence of live poliovirus vaccine strains, and the possible importance of this feature in the community if the vaccine is improperly used. For example, the vaccine has been employed largely in mass administrations where most of the susceptibles were simultaneously given the vaccine, thus permitting little opportunity for serial human transmission; or, it has been administered during a season of the year when wild strains have usually shown limited capacity for spread. This experience should provide the basis for developing useable practices for the U.S.A."

The special committee also said attention should be given to administration to special groups, such as very young children, pregnant women, and susceptible adults. "Even more important is the planned continuation of this program as long as necessary to achieve and maintain the required results," the committee said. The committee was headed by Roderick Murray, M.D., of the National Institutes of Health. Its other members were four M.D.'s and one Ph.D., all of whom were connected with universities except for one M.D. from the PHS's Communicable Disease Center at Atlanta.

Neither the committee nor Dr. Burney anticipated that the live virus vaccine would replace

(*Continued on page 32*)

a breathing spell from asthma

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a rapid way to clear the airway

- **stops wheezing**
- **increases cough effectiveness**
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WASHINGTON (Continued)

the killed-virus Salk vaccine used since April, 1955. "It appears probable that only a unified national program which utilizes each of the available types of vaccine to its best advantage can accomplish the total prevention of outbreaks," the committee said.

Dr. Julian P. Price of Florence, S.C., chairman of the AMA's Board of Trustees, predicted the live-virus vaccine "will be one more powerful weapon against an ancient and crippling disease." He said that physicians "have conscientiously pushed immunization with the Salk vaccine and now, with this new vaccine, the profession is hopeful that even better results can be achieved."

Five states were ready soon after the effective date of Oct. 1 to submit plans for participation in the federal-state program of health care for the needy and near-needy aged persons which recently was enacted into law. The states were Arkansas, Michigan, New Mexico, Oklahoma and Washington.

As of early October, another 25 states were preparing to consider legislation to set up such a program or had indicated a willingness to proceed without new legislation. They were Alabama, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Montana, Nevada, New Jersey, North Dakota, North Carolina, Ohio, Pennsylvania, Rhode Island, Utah, West Virginia, Virginia and Wyoming.

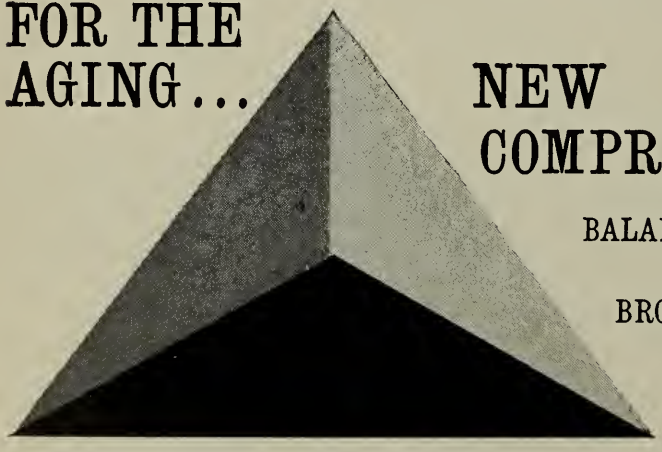
Arthur S. Flemming, Secretary of Health, Education and Welfare, urged all states to take part in the program as soon as possible. But he also said he hopes that Congress in the next session will approve a Republican plan for a supplementary federal-state program to help provide private health insurance for elderly persons who cannot meet their medical expenses.

It appears that the issue will probably arise in Congress next year because some Democrats also have said they will again sponsor legislation that would provide health care for aged persons through the Social Security system.

The AMA has launched a "comprehensive study and action program" to guide Americans

(*Continued on page* 39)

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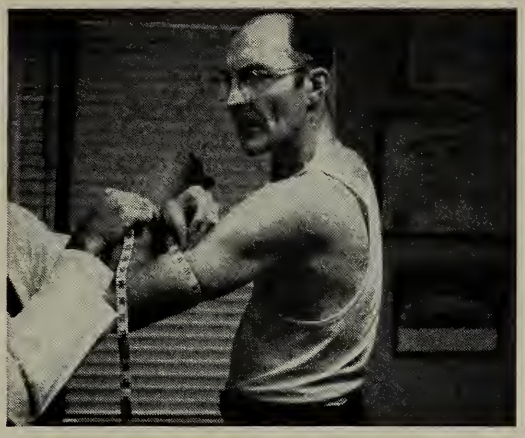
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in spending health-care dollars more wisely.

The AMA's new Commission on Medical Care Costs has set out "to find answers to the many questions being raised about medical care costs and to present the findings frankly and forthrightly to the medical profession and to the public."

The program is "dedicated to promoting the highest quality health care at the lowest cost." Louis M. Orr, M.D., of Orlando, Fla., chairman of the commission, said that "any barrier that stands in the way of this objective should be removed — immediately."

One of these barriers is money wasted on ineffective non-prescription or over-the-counter drug products, such as vitamins, food fads, and rheumatism and arthritis remedies. AMA's Council on Foods and Nutrition has estimated that much of the estimated $350 million spent annually on self-prescribed vitamins is wasted.

The AMA is urging physicians to alert their patients and the public to the latent dangers involved in self-prescribing and to the folly of throwing their health-care dollars away on quackeries.

On another front in the war against quackery, Food and Drug Commissioner George P. Larrick reported that during the past 12 months the FDA had seized falsely promoted vitamins, minerals and other so-called "health foods" valued in excess of $1.5 million. He said that the amount of misinformation, pseudo-science and plain "hokum" on health care reaching the public through books and magazines articles is increasing.

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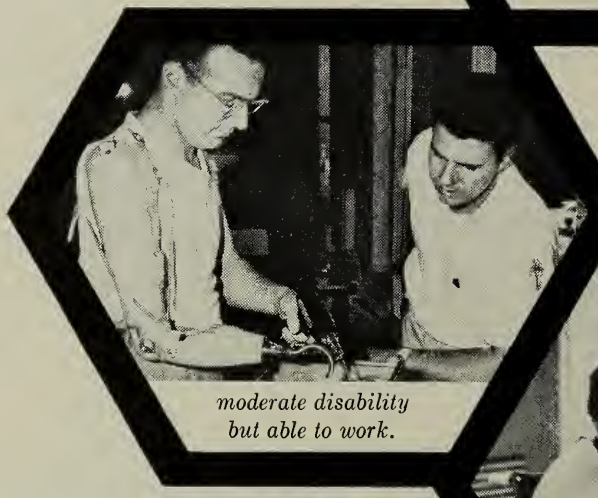
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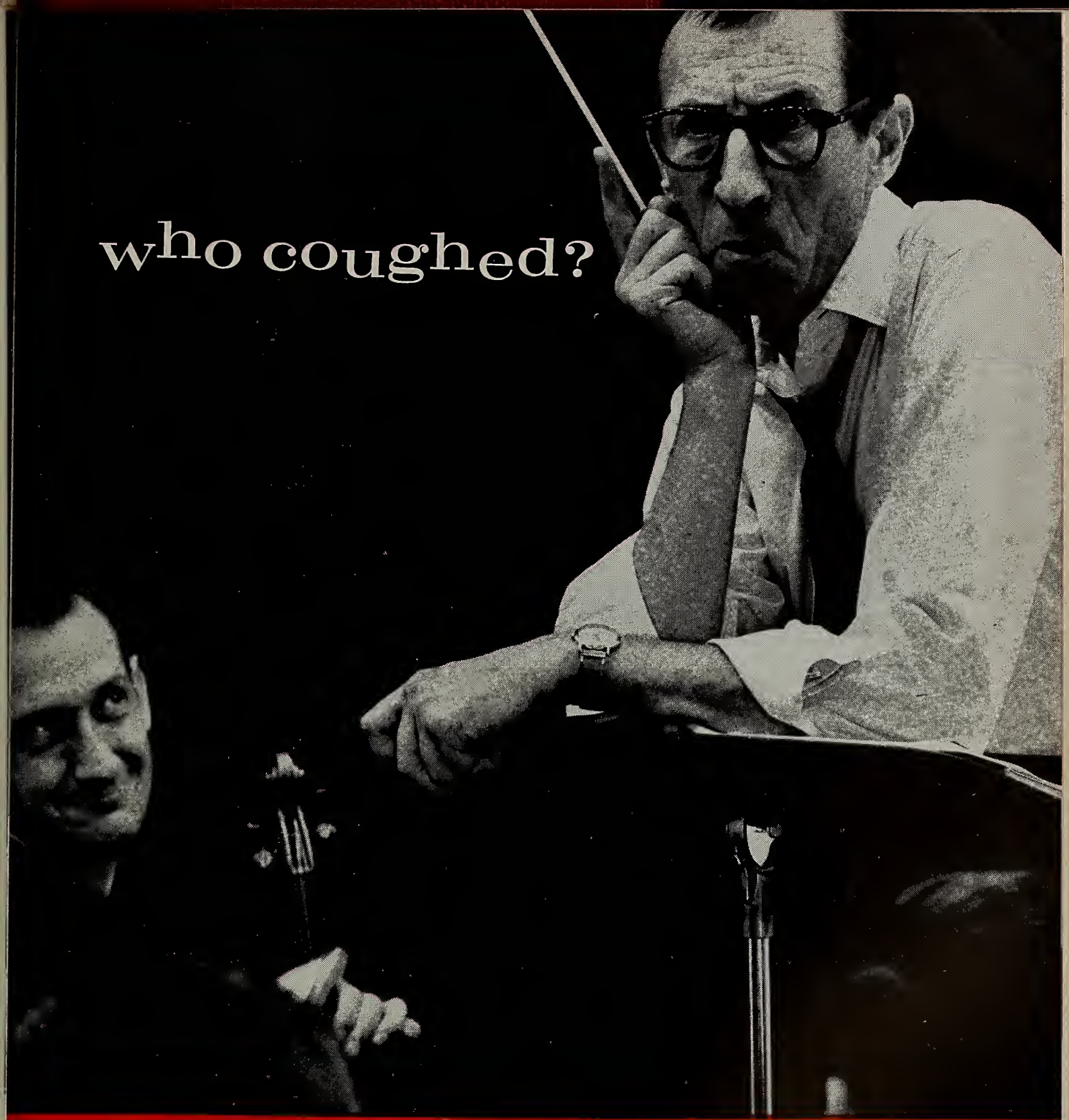
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1. Pomeranze, J. et al.: J.A.M.A. 171:252, Sept. 19, 1959. 2. Walker, R. S.: Brit. M. J. 2:405, 1959. 3. Odell, W. D., et al.: A.M.A. Arch. Int. Med. 102:520, 1958. 4. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959. 5. Lambert, T. H.: ibid. 6. Skillman, T. G., et al.: Diabetes 8:274, 1959. 7. Sugar, S. J. N., et al.: Med. Ann. Dist. Columbia 28:426, 1959.



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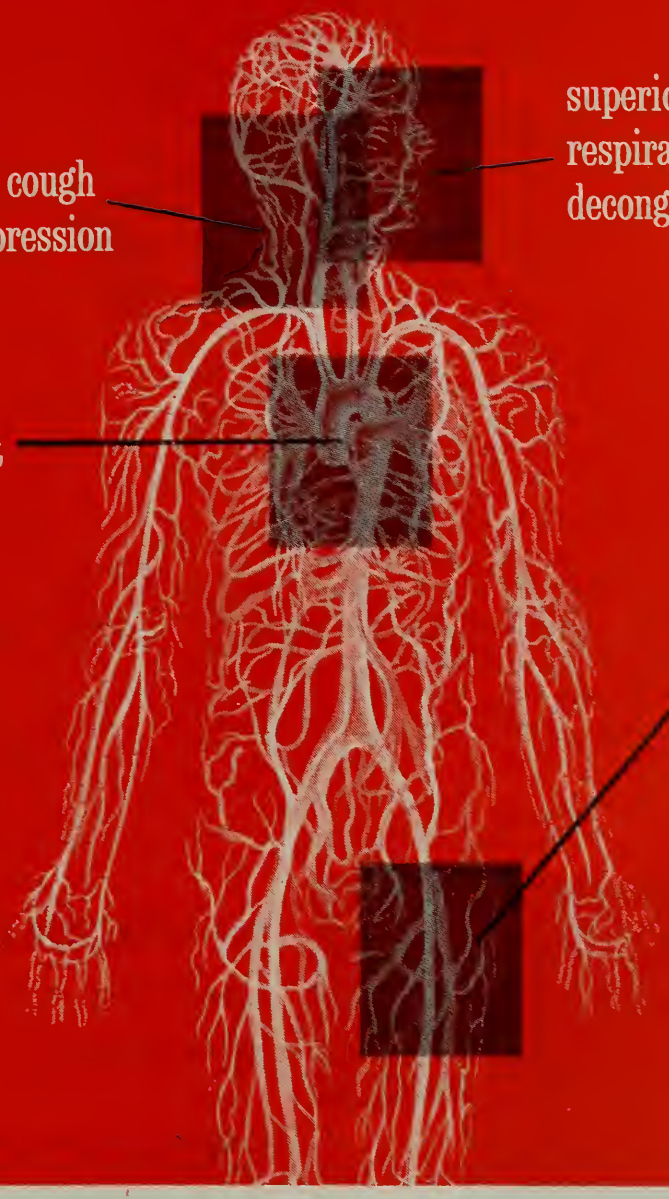
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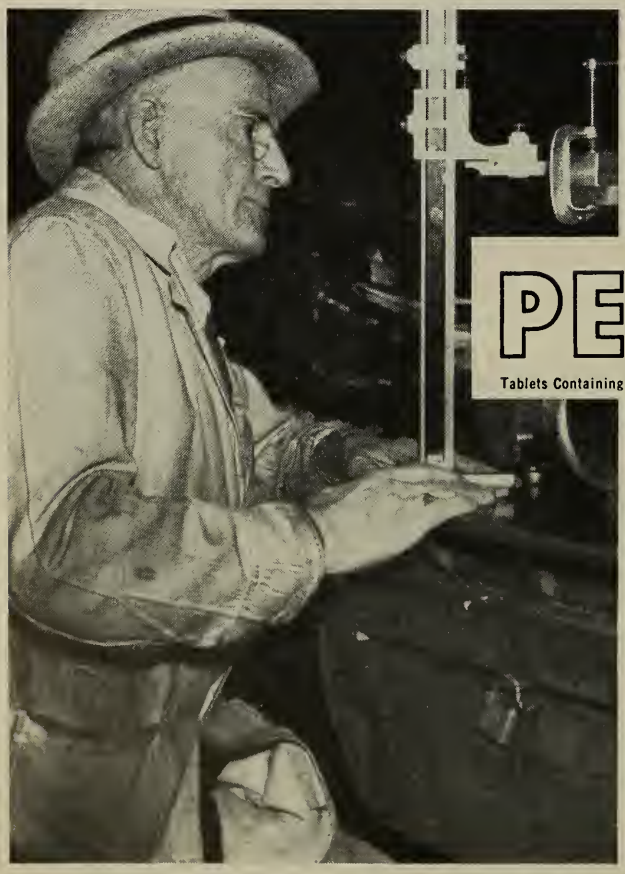
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Vomiting and obstruction

Vomiting is an early and prominent symptom in mechanical obstruction of the small bowel; it is often profuse and the higher the obstruction the more prominent the vomiting. In obstruction low in the ileum, vomiting may be somewhat delayed and it will not be as profuse as in higher obstructions. When fecal vomiting occurs, the obstruction is usually in the small bowel and, of course, the condition is critical. Vomiting is not a prominent symptom of obstruction of the large bowel; in fact, it ordinarily occurs late, and there may be enormous distention without the occurrence of vomiting. When much vomiting does occur in large bowel obstruction, it is often reflex and may be due to peritonitis. The ileocecal valve and sphincter when adequate (in more than a majority of cases) do not permit regurgitation of any particular consequence of the contents of the colon into the ileum, thereby forming practically a closed loop. *Charles Hamilton Lupton, M.D. Mechanical Intestinal Obstruction. J. Abdominal Surgery. July 1960.*



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The ILLINOIS Medical Journal

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Impressions after Five Years of Rural Practice

JACK L. GIBBS, M. D., *Havana, Ill.*

I AM VERY HAPPY to have the opportunity to speak to a group of people who are interested in improving the rural health care of America. In doing so I am, in a small way, satisfying a personal indebtedness. Had it not been for the medical scholarship and loan fund activity, of which the Illinois Agricultural Association is a partner, I would probably not be a doctor today; or at least not a doctor in a rural community.

In 1947 when I was seeking entrance into a medical school and investigating ways of financing my medical education, this scholarship and loan fund was called to my attention by a member of the committee on Rural Health and Student Loan Fund of the Illinois State Medical Society, the other partner in the joint activity. I found that this Joint Student Loan Fund Board would loan me $5,000 and recommend my admission to the state medical school if I met the entrance requirements of the school, and was recommended by the presidents of the Farm Bureau and medical societies of my home county.

The only stipulation was that I sign an agreement to return after my internship to a community of 5,000 population or less to practice general medicine for a period of five years. It was also agreed that I would repay the loan during this five years at the interest rate of 2 per cent per annum. The money is loaned during the four years of medical school at six-month intervals — $625 per semester. To discourage those who would violate their agreement to return to rural practice, there are severe penalty clauses included in the contract.

At this time both the Illinois Agricultural Association and the Illinois State Medical Society have contributed $77,000, or a total of $154,000, to the Joint Student Loan Fund.

Since 1948 a total of 122 students have signed contracts, and 99 of these are still in the program. This discrepancy is due in part to academ-

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ic failures, and in part to withdrawals from school for other reasons of a nonacademie nature.

On Sept. 1, 1959, 32 doctors were in praetiee in rural communities as a result of this program. Eight are now in military service, 17 are interning, 32 are in medical school, 10 are entering school in the fall of 1959, and 15 more are scheduled to enter school in 1960.

As far as the plan is coneerned, no money has been lost, and the fund is beginning to level off, with the objective of the rotation of funds being realized. In other words, as the money is loaned, it is being paid back. Through this fund, some inerease, although minimal at this point, has been made in the number of praeticing rural physicians in Illinois.

Beginning practice

As one of the partieipants in the Illinois Student Loan Fund Program, I entered the praetiee of medieine five years ago in the town of Havana, population 4,500. The nearest hospital was 20 miles away, and eonsultants in most specialties were 50 miles away.

I rented the only office spaee available, which was above one of the hardware stores; and with the aid of my wife, who is a registered nurse, we washed, painted, and redeeorated. I borrowed $300 to buy offiee furniture, waiting room rug, secondhand examining room furniture, and an oil stove with whieh to heat the offiee. The medical supply houses and the local druggist were most generous in advancing basic supplies and drugs. My wife was my reeeptionist, nurse, bookkeeper, housekeeper, and along with me the offiee janitor.

We put an announeement of our hours in the loeal weekly paper, had my name painted on the window, and sat down to await our first patients—to await them with a thrill of anticipation that is diffieult to describe and can be shared only by those who have begun their praetiee of medicine in like manner.

With my stethoscope, blood pressure euff, and reflex hammer, with only my eyes, ears, and finger tips immediately available, I soon became an astute diagnostician; for the words of my teachers were still fresh in my ears—diagnose first , treat seeond. I did no dispensing of drugs, whieh allowed me to concentrate on diagnosis and spend more time with my patients, although I realize that this is not always possible in more remote areas and small villages. At any rate, I learned and learned and learned. The pressure to know and understand is never so great as when one is face to face with the actual problems; and decisions often must be reaehed quiekly and aecurately. The amount of learning experienced and knowledge gained that first year, in retrospect, is staggering. Every cure, no matter how minor the condition, was a therapeutic triumph, and I became adept at the art as well as the seience of medicine. I found that all who elaimed to be siek were not physieally ill, and some of those who denied illness were sieker than they thought. I gained a measure of sympathy and eompassion that I had not had before, and I learned that the family physician is often the family confidant and advisor in nonmedical as well as medieal matters.

Within a few months I was busier than I wished to be. I found myself on the treadmill of general praetice. As more and more patients came, I could spend less and less time with eaeh one. The exhausting and lonely grind of a busy solo practiee, whieh leaves so little time for family and continuing study, soon began to pall, and after one year I sueeeeded in aequiring a partner — a former elassmate with one year's resideney training in internal medieine.

Partnership practice

This has made rural practice more enjoyable for me. We moved into larger modern offiees and aequired such diagnostic equipment as x-ray, an electroeardiograph, and more laboratory faeilities. We were able to hire more teehnical assistanee in the form of a laboratory technician, reeeptionist, and part-time bookkeeper. My wife was relieved of her nursing duties, and we started raising a family. I was able to get away for some postgraduate courses, to attend more medieal meetings, and to become more aetive in community affairs, such as serving on the school board and acting as health and medical advisor to many local health projects.

It would seem that this kind of partnership medical practice arrangement should be encouraged rather than discouraged. It allows the rural physician more latitude in his activities, and he is more apt to keep abreast of medieal progress if he does have an associate. At the same time it compromises very little the close physi-

cian-patient relationship that is so important to the maintenance of optimum medical care.

Establishing a hospital

There were many in my community who were receptive to the idea of a community hospital. We physicians in the town felt that we were not practicing medicine at the peak of our efficiency or our capabilities without one. Attempts at caring for patients in a hospital 20 miles away is a frustrating and time-consuming effort. Office hours are often interrupted with the necessity of a hospital call; and when this entails driving time of 30 minutes each way, it works a hardship on both the doctor, the patient he is to see, and the patients he leaves waiting behind. The hardship is particularly severe where obstetrics is concerned. To illustrate the travel time and distance that can be consumed, I recall the 16 hour period one night when I delivered four babies and got home each time before I was called for the next one. This entailed driving a total of 160 miles and spending approximately four hours on the highways — a dangerous pastime in these days.

At any rate, we pitched in with our community leaders and interested citizens. Since we were not immediately eligible for Hill-Burton Funds, we started a drive for a community hospital that initially included ten townships in the proposed tax district. By the time the campaigning was over nine of the ten townships, or all but our own of Havana, had withdrawn from the proposed tax district. Despite the loss of the expected revenue, we did build a 50-bed hospital, which within less than two years of its opening has been fully accredited by the Joint Commission on Accreditation of Hospitals. Of this joint accomplishment we and our community are justly proud. Problems of hospital personnel, such as shortage of nurses, are to some extent being solved by the formation of nursing scholarships offered by our very active women's auxiliary, service clubs, and memorial funds.

It is interesting to note that in our particular situation our plans for a community hospital were almost defeated by lack of support from our adjacent rural communities. The proposed taxation was to be 10 cents on the $100 assessed evaluation of real estate and personal property. Although I recognize the inequities which often arise from this source of revenue, I feel that if we of the rural areas are to maintain high standards of medical care and attract high caliber men to practice medicine, we must support construction of this type of facility. It is something to consider — that the privilege of administration and ownership of our hospital may compensate for the difficulties of gaining local financial support. I believe it is actually better, in the long run, for a community to endure the financial obligation of hospital construction than to accept subsidization that may culminate in increasing federal regulation, control, and interference.

Rural physicians needed and wanted

It would seem from what I have said so far that all is well on the rural front. It would appear that the future of rural medical care is secure. Unfortunately, I don't think it is. By and large, the efforts to date hardly dent the surface of a steadily mounting deficit of rural practitioners. The number of general practitioners in the medical populace, country wide, has declined in recent years from 75 per cent to 40 per cent, and nowhere is this deficit of practitioners more apparent than in the rural communities.

I recently received a letter from an acquaintance in a town of 2,000 people requesting some assistance in procuring for them a physician for their community. As I pondered this request and recalled efforts made by other communities to obtain physicians, I experienced a sense of humility, mingled somewhat with pride I suppose, to think how we as physicians were so necessary, so sought after. And in the same twinkling I was impressed by the very little that was actually being done by organized medicine to solve the dilemma of these small communities. I continue to be impressed by the lethargy and inertia with which this problem is being treated. I say to myself, "Do the educators and the higher echelon of medicine feel that the family physician is no longer necessary? Do they feel that his presence in the community can be replaced by the large clinic 50 miles away?"

If that is so, why is it that in the face of this dearth of family physicians, our communities are flourishing with osteopaths and chiropractors. Why is it that many small communities are dependent upon foreign trained physicians for their medical care? It is simply because these

physicians are willing to do a job that we are failing to do, and this tremendous deficiency in family-physician supply for the small community must be met one way or another.

In the light of my own limited experience, I am convinced that people want to have a family doctor. I am convinced that they want a family doctor just as they want a family minister, druggist, or dentist. I believe that his presence in a community promotes a sense of security and peace of mind, assurance that an interested member of one's own community is at hand to deal with the problems of health care that may arise.

I am just as firmly convinced that the medical interests of a people really are best served when care is initiated promptly in the community in which the patient resides; that although specialized treatment and facilities may be necessary later, the presence of a family medical advisor and coordinator enhances the over-all quality of care. It is at this grassroots level that the sympathetic relationship between physician and patient—the so-called doctor-patient relationship — has its best chance for survival and growth. And make no mistake about it, it is all the things meant by and incorporated in this loosely used phrase — the doctor-patient relationship —that is our first and strongest line of defense against the socialization of medicine. When the doctor-patient relationship is gone, who cares, except the doctor, whether medicine is socialized or not.

It would seem paradoxical to me that our profession, which has given to the United States the highest caliber of medical care to be found anywhere, some of the greatest advances in the world in the fields of diagnosis, treatment, and medical technology, should ignore the need for that basic medical commodity for which the community longs — the family physician. In the last five years I have become increasingly concerned over these steadily yet subtly changing concepts and attitudes toward family care.

Physicians shun general practice

I do not feel that the increasing deficit of rural physicians is simply faulty distribution, as some claim. We need only to look at the surveys concerning the aspirations of graduating medical students to see the reasons for our vanishing colleagues. I have recently been through the educational process and for the past few years have been exposed to actual contact with patients, and with my specialist consultants. I also have read Life, the Readers Digest, and the Ladies Home Journal, and to me the explanation for the decision of the majority of the graduates not to enter general practice is readily apparent. It is my impression that this reluctance stems from (1) feelings of inadequacy in the over-all field of general medical care, as the usual training period nears its completion, and (2) lack of professional status.

It is in the medical schools, I believe, that the first seeds are sown which breed feelings of inadequacy. Present-day medical education is not geared to prepare the student for the general practice of medicine. Since much of the student's training takes place in the university hospital, he is exposed too often to the bizarre and unusual disease, and too little to the more commonly seen diseases that confront the family physician. He, in fact, may finish his medical education with the distorted impression that general medical practice is composed of these cases which confound the diagnostic efforts of even his renowned professors.

It is human nature for the educator to dwell on the more difficult aspects of his specialty, but he often sacrifices time that could be spent on the principles of diagnosis and treatment of conditions that the family physician should be able to care for. For example: I recall lectures on mastoid surgery, which I never expect to do, but no suggestions for the office treatment of the chronically draining ear, nor the best methods for stopping a stubborn nose bleed that may get one out of bed at midnight.

I do not mean to suggest that we should sacrifice the teaching of basic principles to a hodgepodge of minor therapeutics, but I do feel that the curriculum needs a basic re-evaluation of its aims and objectives, in the light of present-day medical practice, both general and specialty.

In regard to lack of status, I would say that doctors themselves are no less status seekers than the rest of the populace; and when it comes to professional status, they are particularly sensitive. The student needs only to read the lay magazines and newspaper articles to realize what the professional standing of the family physician is with many laymen.

In a recent Life magazine article the general practitioner was described as the "jack of all

trades," and, of course, what normally follows this phrase, although left unsaid in the article, is "master of none."

In my own experience this attitude is often overcome in rural practice by time and a conscientious effort on the part of the physician. However, since third parties such as the unions and Veterans Administrations have entered the medical care field, my ego has been bruised, in some instances, by not being able to treat patients because I am a general practitioner.

Many of the specialty consultants, particularly those who have not had the benefit of some general practice, are often quick to criticize the efforts of the generalist. It is unfortunate that this stigma, which puts the family physician at the bottom of the status pole, often starts in medical school, where by innuendo if not in words, some of the teaching cases may be presented as diagnostic failures or oversights of the local medical doctor. By the time a student is through school, he is well aware of these status levels and also of his feelings of inadequacy in the over-all field of medical care. He is certainly not to blame for the decision he makes.

Upon completing my medical education I too was impressed by the lack of status of the rural physician. I too felt the apprehension and anxiety that accompanies the thoughts of finally meeting the test of actual medical practice. Although the anxieties have dissipated with experience, my concern over the status of the rural physician within the medical profession has increased. The role of the family physician or generalist, at this critical period in medical history, is ill-defined, and I feel that every effort must be made by medical educators and organized medicine to solve the problem.

I do not feel that the problem can be solved simply by the organization of generalists. If basic training for medical care is inadequate, then let's change the training. If good medical care is being compromised, let us clearly define the area of general medical family care, then prepare the man to do this specific job, so that he may go to it with the blessings and not the misgivings of his teachers, so that he may enter it with confidence and pride.

Raising the status of general practice

He should be exposed at some point in his training to general practice itself. Since 1937 Wisconsin has had a medical school plan whereby every student during the last two years of his medical curriculum must spend one quarter with a general practitioner. This practitioner, whose competency and willingness to teach have been established, takes the student into his home and office. Here he has an opportunity to see for himself the variety of cases seen by the rural physician. He is able himself to evaluate the quality of care given and becomes aware of the economic burden that medical care often poses for the family. He is exposed to the art as well as the science of medicine. He is in a better position to choose between specialty and general practice, and the exposure of every student to this plan helps keep the status of the generalist on its proper plane. Preceptor plans are becoming popular again in other schools and, I feel, should definitely be encouraged as one means of exposure to more ambulatory clinical material at the student level.

Other plans to accomplish this objective are being used in certain medical schools. One such plan is for a student to have one or two indigent clinic families for whom he is the family physician throughout his four years. These are encouraging signs of progress in this field.

It seems only right to me that our state medical schools, supported by the taxes of the rural as well as the urban population, should make a specific effort to graduate students trained to handle the needs of the rural as well as the urban communities, if their objectivies are to be justified. To do this, however, a basic change in the philosophy of our medical educators is necessary.

Advantages of rural practice

It has occurred to me that it might be made a prerequisite for all students gaining admission to state medical schools to agree to spend one or two years in general practice before specialization. This would serve to make a greater number of physicians available to rural communities; distribution would force this. Secondly, a greater number of physicians, even those who eventually specialize, would be made more aware of medical economics from the standpoint of the patient; and it would encourage the return of the doctor-patient relationship. One cannot possibly work at the small community level without being touched by the pathos and tragedy of disease and death, without soaking up a bit of

human sympathy, compassion, and understanding—these qualities which often are as important to our treatment of the patient as are the medicines we prescribe.

The exposure of the new physician to a rural community would not only accomplish the objectives I have just mentioned; it would also make evident certain basic truths about rural practice that would to a great extent counteract the misconceptions fostered during training.

For one thing, he will become convinced that he can provide good medical care in the rural community; that its provision is dependent chiefly on his own individual professional integrity, intellectual honesty, and personal diligence.

If he has served his community well, he will soon discover that he enjoys a degree of personal and professional status in that community that would be the envy of his colleagues in the city. He will also find that recognition of this status is often revealed in heart-warming ways that would find difficult expression in the city.

He will discover that financial security will arrive sooner to him than to the city physician. This is due to the fact that his patient capacity will reach its peak much sooner, and his percentage of collections will probably be higher, despite the fact that his fees will differ only slightly.

He will find that he is closer to cultural and recreational facilities than he thought he would be; and if some of these things are lacking, a measure of satisfaction may be gained by helping develop them.

May I re-emphasize however, in closing, that words expounding the rewards of rural practice will fall on nonexistent ears unless we can somehow meet the deficiency in the number of men available for general practice. Perhaps it is to you the farmer and the farm organization that we must look for the solution to this problem. Perhaps it is from your own ranks that we must draw the greater percentage of future doctors. As farm mechanization progresses and more farm children grow up and go into other occupations, let us encourage them — finance them if necessary — to go into medicine and its allied fields and bring them back home to meet the needs of rural medical care in areas with which they are familiar.

I realize that many of you here cannot change these things readily, but your mere presence speaks for your interest in medical care, and I hope you too may benefit from these impressions.

The theme of this Conference, "Meeting Challenge with Responsibility," is quite appropriate to many of the areas that I have discussed. I am looking forward to the time when we as physicians, along with you, will be responsible to the degree that this challenge to rural medical care will be successfully met.

Malnourished unseen

In many parts of the world, one may be misled at first sight by the good physiques of the people, but it is not unusual to find that life expectancy is short and mortality among children extremely high. The weak or malnourished are not seen walking down the roads and streets. Wherever malnutrition exists, it is always the children who suffer most. *Arnold E. Schaefer, Ph.D., and Frank B. Berry, M.D. U.S. Interest in World Nutrition. Pub. Health Rep. August 1960.*

Serious side effects from steroids

An important side effect of cortisone is its tendency to deplete the body's potassium stores while inducing sodium retention. All the steroids of the cortisone family tend to induce diabetes mellitus or to activate latent diabetes. The clinical manifestations of steroid-induced diabetes is severe enough to require all the preoperative and postoperative skill necessary to manage patients with this metabolic defect. *Eugene F. Traut, M.D. The Surgeon and Steroids. J. Internat. Coll. Surgeons. September 1960.*

Ocular, Anatomic, and Physiologic Changes Due to Contact Lenses

C. J. Black, M.D., *Elmhurst*

A contact lens is a prosthesis. Its function is to replace by its own convex surface that of the anterior surface of the cornea where most of the refraction of the eye is accomplished. Since other types of prosthesis can cause changes of the anatomy they approximate, one would expect the same of contact lenses. It is naive to think contact lenses would not alter the physiology and the anatomy of so highly a specialized tissue as the cornea. Then if these plastic prostheses are to be worn successfully with no pathologic changes, an adaptation of this specialized tissue to its environment must occur.

What occurs during the successful adaptation of the cornea to the lens?

What happens to the anatomy and physiology of the cornea on less successful cases?

I will review some significant factors.

To maintain corneal transparency, corneal metabolism must be maintained. Proper corneal metabolism is dependent on adequate precorneal fluid circulation, adequate limbic vascular circulation, and proper maintenance of aqueous humor properties, as well as the maintenance of the integrity of the epithelium against mechanical forces of the pressures and motion of the lens that occurs on blinking, particularly at the apposition of the contact lens and the cornea.

Kinsey[1] claims, "The state of detergence seems to be associated with corneal transparency since after an increase in hydration, as for example, that which occurs following damage to the epithelium or endothelium or after reversal in the osmatic pressure relations between the inside and the outside of the cornea, the cornea becomes cloudy, eventually opaque."

Haze and halo formation on wearing a contact lens are thought to be due to the imbibition of fluids, particularly by the mucoid material that surrounds the collagenous corneal fibers of the stroma, causing a swelling of the cornea, separating the lamellae, and probably changing the refractive index of the intrafibrillar fluid.[2]

Ascher[3, 4] claims that aqueous veins of the sclera under the scleral contact lenses could be blocked by pressure at 3 and 9 o'clock where the veins are most prevalent, resulting in halo formation. Relief of pressure of the lens over these areas by indentations fabricated in the scleral lens flange resulted in correcting this. Air bubbles also had a similar effect.

Huggert[5] reported a rise in intraocular pressure when corneal scleral lenses were worn.

Langham,[6] and Smelser, and Ozanico[7] found that absence of atmospheric oxygen altered the metabolism of the cornea.

Smelser and Ozanico[8] fitted guinea pigs with scleral lenses and found the corneas had haze and halo formation. These corneas had a thicker stroma, and, most important, the glycogen content of the epithelium was reduced. The authors concluded, "Glycogen depletion of the corneal epithelium was a striking phenomenon and occurred concomitantly with the development of corneal haze and edema."

In essence, it is possible that metabolic processes are involved in fluid regulation: certainly the above experiment would imply that anaerobic conditions under a contact lens use the glycogen stores more rapidly to a point of exhaustion followed by imbibition of fluid.

Hirano[9] did similar work but with corneal lenses (not scleral) on rabbits. He separated his experiments as follows:

Experiment 1. "Relationship of wearing time and corneal changes"

No adaptation period was used; the lenses were merely placed on the eyes. The range of wearing time was from three hours to ten days.

Clinical results:

6 hrs.—Discharge and injection of the bulbar conjunctiva.

Presented at the annual meeting of the ISMS in May 1960.

12 hrs.—Ciliary injection.
24 hrs.—Corneal luster was gone and haze was noted.

Histologic results:
12 hrs.—Corneas were intact and limbal vessels were dilated.
24 hrs.—A widening of intercellular spaces and disarrangement of cells of the corneal epithelium; stroma thickened; iris vessels dilated; glycogen changes were limited to the epithelium and depleted only under the area covered by the lens in 24 hours; ribonucleic acid and amino acid of the protoplasm showed a slight change only after 24 hours; DNA was intact.

Experiment 2. "Recovery Process"
No adaptation period was used: lenses were worn for 12 hours. Lenses were removed, and after various periods of time the eyes were autopsied.

Results:
3 hrs.—Glycogen stores began to return, and all signs of conjunctival injection and discharge and ciliary dilatation were gone.
12 hrs.—Glycogen stores were back to normal.

Experiment 3. "Effect of Habitual Wearing"
Rabbits' eyes were allowed to slowly adapt to the contact lens as in humans. It took four to five weeks to reach a 12 hour daily wearing time.

Results: When using the P.A.S. staining technic for glycogen, no changes seem to occur. In five weeks, histologic examination revealed no changes. This would imply that by a definite procedure of slowly increasing the wearing time of contact lenses, changes during adaptation can occur in the cornea that will permit them to be worn with little evidence of corneal physiologic disorganization.

In summary, the following can be inferred: The epithelium must remain intact or hazing and halo occurs. A proper glycogen reserve must be maintained (1) by proper precorneal fluid circulation, as it is necessary that no anaerobic situation occur beneath the contact lens, and (2) by adapting the cornea slowly to its new environment. Above all, the corneal limbic vascular plexus must not be impeded by pressure applied by the contact lens.

Causes of ocular changes

The manner in which the bearing surface of the inner surface of the contact lens approximates the anterior surface of the cornea is significant. Corneal contact lenses do not entirely float on tears but do have areas of bearing where they touch the cornea. The lenses never remain stationary but on blinking move in a linear fashion across the eye as well as rotate in a circular fashion. This motion in conjunction with the location of and the total area of approximation of the lens on the eye will determine whether or not and where epithelial disorganization will take place.

Another significant factor that causes ocular changes is the manner in which precorneal fluid flow is maintained, as well as interference with the limbic vascular flow or venous flow of sclera. The manner in which the bearing surface of the inner surface of the contact lens approximates the anterior surface of the cornea determines the degree of disorganization of the elements of the epithelium.

Epithelial changes can be relatively minor, limited to only intermittent stippling as evidenced by a few pin-point, grayish areas occurring only at the end of the day. Or there may be more evidence of disruption in an unusual amount of stippling. Occasionally on prolonged wearing one may see a grayish speckling of the cornea that does not stain with fluorescein, possibly a hyperkeratosis with no clinical symptoms. Irregular mottling of the surface epithelium and abrasions may also occur.

Stromal changes may vary from none to an increase in translucency with measurable change in swelling as per the use of a pachyderm.

Conjunctival changes also may vary from none to chronic injection of the perilimbal vascular plexus usually associated with chronic stippling. Initially, of course, on placing the lens on the eye, particularly during the adaptation period, there is bulbar conjunctival injection. In addition, a palpebral conjunctival injection with a red linear area 1 to 2 mm. from the margin of the upper lid may be seen as a result of the trauma caused by the edge of the lens.

Precorneal fluid changes cause ocular changes. There is, of course, initial tearing which disappears. Chronic tearing usually is indicative of an improper curvature of the inner surface of the lens. The lens has too flat an inner radius of curvature. The changes are from none to a shift to the alkaline side when abrasions occur. This shift can be checked by the micropipet technic and a Beckman pH indicator. By this technique, minor stippling does not show a shift of pH. Occasionally an increase in cellular or formed elements may occur in the fluid in certain poorly fitted patients. These lenses are usually but not necessarily steep lenses (too sharp a radius of curvature); they may be poorly fabricated with improper blending of curves of the inner surface of the lens. Micro-bullae located in a group usually are pathognomic of poor precorneal fluid circulation. In some instances the lids tend to be puffy with thick edges.

Anatomical changes involve the general curves of the front surface of the cornea. They may be unchanged, as measured conventionally by the keratometer, or warped out of shape. Studies on fitting different types of fabrication of the inner surface of the lens gives one the impression that the corneas and surface tend to conform to that of the inner surface of the lens. Highly astigmatic corneas are forced to more or less conform to the inner surface of the lens. Because of the irregularities of the highly astigmatic cornea, precorneal fluid flow is more easily obtained.

Flat lenses (i.e., those fitted with a greater inside radius of curvature than that of the center of the cornea) tend to warp the cornea, making it flatter and the patient more myopic. They cause stippling or mottling at 12 o'clock or occasionally at the center of the cornea with conjunctival injection photophobia as well as halo and hazing. If the process is allowed to continue, the abrasions become more extensive, and an increase in translucency of the stroma occurs causing greater reduction in visual acuity. The irritation at first is annoying as a burning and stinging sensation followed by an increase in tearing and photophobia. Later the eye becomes painful, more so on the removal of the lens. The changes due to a flat lens are mechanical in that the motion and pressure of the lens are transmitted to the corneal surface over an inadequate area. In essence, there is an improper bearing surface relationship between lens and cornea; improper precorneal fluid flow is not the problem.

Steep lenses (i.e., those fitted with a shorter inside radius of curvature than that of the cornea) tend to warp the cornea making the areas steeper. Poor precorneal fluid flow results in micro-bullae formation near the center of the lens. Stippling occurs over the bearing area occasionally, and it may be merely a small amount appearing as a crescent-shaped area, or it may be in oval or nearly ring-shaped areas located paracentrally. The usual sequence of conjunctival injection, photophobia, burning and stinging, hazing, and finally pain and opacification occurs if this relationship is allowed to continue.

Corneal sensitivity changes occur. Patients have an alteration of sensation. They experience no pain on removal of the lenses, yet may have a severe punctate keratitis caused by overwearing their lenses during the acclimation period. In about two hours a pain occurs with blepharospasm and photophobia that is severe enough to necessitate treatment. Prior to experiencing the pain they have the ability to feel a foreign body under the lens and do respond to touch. This would imply that a parasthesia occurs. Placing a contact lens so that its bearing area is on the corneal limbic vascular plexis results in a dramatic conjunctival injection and a rapid (in a few hours) haze formation. Foreign bodies and hot temperatures annoy the contact lens wearer. Because a contact lens patient may appear in the office with no signs of disorder does not preclude the fact he may have moments when some transient stippling or conjunctival injection occurs. Like denture patients, contact lens patients do have their good and bad moments.

Summary

Patients wearing contact lenses may experience varying degrees of corneal disruption. Chronic corneal physiologic changes are probably (1) an adaptive alteration of carbohydrate metabolism and ribonucleic acid metabolism enabling the cornea to live in its new environment, and (2) an alteration of sensitivity of the cornea. The anatomical shape of the cornea may be altered in so far as its radius of curvature is concerned as measured by the keratometer. Other chronic changes as evidenced clinically are none to occasional transient, small areas of stippling that stain with fluorescein, or nonstaining areas of a grayish stippling that give the epithelial surface a speckled effect.

REFERENCES

1. Kinsey, V. E.: An Explanation of the Corneal Haze and Halos Produced by Contact Lenses, Am. J. Ophth. 35:691-695, 1952.
2. Smelser, G. K.: Relation of Factors Involved in Maintenance of Optical Properties of the Cornea to Contact Lens Wear, A.M.A. Arch. Ophth. 47:328-343, 1952.
3. Ascher, K. W.: Aqueous Veins and Contact Lenses, Am. J. Ophth. 35:10-20, 1952.
4. Ascher, K. W.: Aqueous Veins — Their Status Eleven Years After their Detection, A.M.A. Arch. Ophth. 49:438-451, 1953.
5. Huggert, A.: Increase of Intra-ocular Pressure When Using Contact Lens, Acta Ophth. 29:474, 1951; and Intra-ocular Pressure in Glaucomatory Eyes Following Use of Contact Lens, Acta Ophth. 31:141-152, 1953.
6. Langham, M.: Utilization of Oxygen by the Component Layers of the Living Cornea, J. Physiol. 119:461-470, 1952.
7. Smelser, G. K., and Ozanico, V.: Importance of Atmospheric Oxygen for Maintenance of the Optical Properties of the Human Cornea, Science 115:140-145, 1952.
8. Smelser, G. K., and Ozanico, V.: Structural Changes in Corneas of Guinea Pigs After Wearing Contact Lenses, A.M.A. Arch. Ophth. 49:333-340, 1953.
9. Hirano, J.: Histological Studies on the Corneal Changes Induced by Corneal Contact Lenses, Japanese J. Ophth. 3:1-9, 1959.

Cholesterol Synthesis, Diet, and Species

George E. Cox, M.D., and C. Bruce Taylor, M.D., *Evanston*

The casual relationship of excess plasma cholesterol to atheroselerosis behooves investigators to determine the sources of plasma cholesterol, which knowledge might greatly facilitate control of plasma eholesterol levels. In considering this subject, three questions can be asked which may superficially appear to be but different statements of the same problem; they are sufficiently distinct and relevant, however, to justify a closer look. (1) What are the sources of plasma eholesterol? (2) What are the sources of the excess eholesterol in cases of hypereholesterolemia? and (3) Why is the plasma eholesterol elevated in cases of hypereholesterolemia? Question 3 would seem to be more relevant to the control of hypereholesterolemia. However, no explanation has yet found universal acceptance, and the numerous, poorly understood areas in lipid metabolism engender a feeling that this question is likely to require a great deal of additional study. The answer to question 2 would surely help to answer question 3, but no experimental design has even been suggested for clearly and definitively answering question 2. Question 1 is doubly attractive in that it should contribute to the ultimate solutions to 2 and 3, and it is susceptible to fairly precise study by several different experimental techniques.

The sources of plasma eholesterol (question 1) were determined first for the dog and the rat. In both species the liver was shown to be pre-eminent over other tissues in *in vitro* comparisons of cholesterol synthesis rates. In both species, *in vivo* measurements of the uptake of labelled acetate into plasma cholesterol demonstrated the pre-eminence of liver over other tissues as a source of plasma cholesterol. Later studies by other techniques have consistently confirmed the original conclusions that in low cholesterol-fed rats and dogs the liver is the major source, and other tissues a minor source, of plasma eholesterol[1,2]. The same studies in rats, dogs, rabbits, and monkeys demonstrated and confirmed the rapid suppression of endogenous eholesterol synthesis after ingestion of eholesterol. In this phenomenon also, the liver demonstrated pre-eminence, with little or no such homeostatic response by other tissues.

Gradually but definitely the conclusions of the dog and rat data were assumed to be directly applicable to the human. Assumptions and calculations, supported by no specific experimental data, fostered the notion that the human liver synthesizes eholesterol at the rate of about 2 Gm. per day, and therefore — via the homeostatic suppression of its eholesterol synthesis — can compensate for absorption of dietary eholesterol up to about 2 Gm. per day. This is more eholesterol than most Americans get in their food; dietary eholesterol, therefore, came to be regarded as insignificant.

More recently, specific data have become available from studies on the sources of plasma eholesterol in humans. Several years ago, *in vitro* tissue-slice incubation studies (on viable surgical biopsies of liver from patients undergoing elective surgery for non-hepatic conditions) indicated a low rate of eholesterol synthesis in human liver, in the range of 0.1 Gm. per entire liver per 24 hours[3]. However, there has been no adequate comparison of the relative eholesterol synthesis activity, *in vitro*, of liver and other tissues. In the light of several different studies demonstrating a continuous synthesis of plasma eholesterol in humans on the order of 2 Gm. per day, it was suggested that the over-all extrahepatic tissues of the human must greatly exceed the liver as a source of plasma eholesterol. As measured by the same techniques in each species, hepatic cholesterologenesis is much lower in humans than in dogs and rats.

Somewhat later, a study of the influence of diet upon the uptake of labelled acetate into plasma eholesterol failed to demonstrate any

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From the department of pathology, Evanston Hospital Association.

**While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the authors and do not necessarily represent the official view of the committee.*

significant and consistent suppression of acetate uptake by a cholesterol-rich diet[4]. This was tentatively interpreted to support the concept of liver being a minor source of plasma cholesterol synthesis in the human, such that the over-all acetate uptake curve might be little affected by suppression of hepatic cholesterologenesis. The same technique simultaneously applied to dogs and to humans yielded strikingly different data, inasmuch as 90 to 95 per cent suppression of acetate uptake was obtained by cholesterol feeding in the dog.

A preliminary report of a study still in progress described another evidence of a marked species difference between dogs and rats versus humans[5]. In this study, cholesterol-rich diets labelled with 4-C-14-cholesterol, using egg yolk as a natural vehicle, were fed to healthy, active adult volunteers. The egg yolk diet supplied enough cholesterol to suppress hepatic cholesterol synthesis, if the liver in man undergoes homeostatic suppression in a fashion similar to lower animals. Radioassay of serum cholesterol permitted direct calculation of the amount of serum cholesterol coming from the diet. The amount from the diet should be equal to the amount of serum cholesterol that would come from the liver if none were coming from the diet. This amount was found to be between one-fourth and one-third. Presumably then, at least three-fourths of the plasma cholesterol of these human subjects was derived from cholesterol synthesis in extrahepatic tissues.

Similar egg yolk diets fed to dogs rapidly replaced as much as 90 to 95 per cent of the plasma cholesterol with dietary cholesterol, indicating a residual extrahepatic synthesis of plasma cholesterol amounting to only 5 to 10 per cent of the total plasma cholesterol. Thus, this technique confirmed previous studies in dogs in which the liver was found to be the normal major source of plasma cholesterol; it also confirmed the recent studies in humans which demonstrated a great species difference between the human and the dog and rat.

Summary

In summary, there is now reasonably direct and specific data from three different experimental techniques supporting the concept that in man the liver supplies a small part of plasma cholesterol. The extrahepatic tissues supply the major part, and diet is capable of supplying a significant part up to one-fourth or one-third of the total amount. The difference between these conclusions and previous conclusions from data on dogs and rats points up the danger of extrapolating data from lower animals to humans. The low rate of hepatic cholesterologenesis in humans may also be responsible for the failure of several cholesterol synthesis inhibitors which in animal studies demonstrated considerable activity (usually in liver tissue) but which in *in vivo* studies in humans generally have not proven to be effective. Apparently, for cholesterol synthesis inhibitors to be effective in the human, they must act in extrahepatic tissues rather than primarily in hepatic tissue.

Further, it should be emphasized that merely demonstrating that plasma cholesterol receives cholesterol via both endogenous synthesis and absorption from foods (answer to question 1) does not in any sense define either the source of the excess cholesterol (question 2) or the reason for the elevation of plasma cholesterol (question 3) in hypercholesterolemia.

REFERENCES

1. Tennent, D. M., Zanetti, M. E., Atkinson, D. I., Kuron, G. W., and Opdyke, D. F.: The Endogenous Origin of Blood Cholesterol, J. Biol. Chem. **228**:241, 1957.
2. Morris, M. D., Chaikoff, I. L., Felts, J. M., Abraham, S., and Fansoh, N. O.: The Origin of Serum Cholesterol in the Rat: Diet versus Synthesis, J Biol. Chem. **224**:1039-1045, 1957.
3. Davis, C. B., Jr., Cox, G. E., Taylor, C. B., and Cross, S. L.: Cholesterol Synthesis in Human Liver, Surgical Forum **9**:486.
4. Cox, G. E., Counts, M., Wolski, J., Alvarez, J., and Taylor, C. B.: The Effects of Dietary Cholesterol upon the "Synthesis" of Plasma Cholesterol in the Human, Circulation **18**:493, 1958.
5. Taylor, C. B., Patton, D., Yogi, N. and Cox, G. E.: Diet as a Source of Serum Cholesterol in Man, Proc. Soc. Exper. Biol. & Med. **103**:768, 1960.

A man too busy to take care of his health is like a mechanic too busy to take care of his tools.—*Spanish Proverb*

Postoperative Oliguria

Cook County Hospital

Moderator:
Robert Baker, M.D.
Associate Director of Surgical Education, Cook County Hospital

Discussant:
Lionel Bernstein, M.D.
Assistant Director of Research, Hines Hospital; Assistant Professor of Medicine, University of Illinois College of Medicine; Attending Physician, Cook County Hospital

Dr. Robert Baker: The subject of this week's conference is postoperative oliguria, an always difficult problem in surgery and one whose solution taxes the resourcefulness of surgeon, internist, and biochemist alike. For purposes of our discussion I would define oliguria as decreased urinary output of any degree and for any reason. Its causes will be brought out in the course of the presentation.

Our discussant is Dr. Lionel Bernstein, a former County Hospital intern and resident, whose particular interest lies in the field of fluids and electrolytes. Dr. Bernstein is called upon to manage these problems frequently, and we shall endeavor to draw upon this experience extensively in the case analyses. Postoperative oliguria is an always perplexing therapeutic problem; its general aspects will be dealt with in an attempt to establish logical principles in the approach to these cases.

Case 1.

Dr. William Reed, surgical resident: This 58 year old, white male was admitted to the surgical service of the Cook County Hospital with the chief complaint of bleeding per rectum and the passage of bloody mucus for five months. He had lost 10 pounds in weight, and his family said he looked "washed out." His medical history revealed only cholecystectomy for gallstones three years previously.

Physical examination revealed a pale, somewhat undernourished white male whose blood pressure was 116/70 mm. Hg, pulse rate 80 per minute and regular. Examination of his heart, lungs, and abdomen was negative. On rectal examination there was a friable, hard mass at the tip of the examining finger; this mass was immobile, seemed intraluminal, and was located on the posterior and right lateral rectal wall. A biopsy was reported as adenocarcinoma.

Urinalysis was negative, specific gravity 1.024. The electrocardiogram and intravenous pyelogram were normal. Hematocrit was 26 per cent, red blood cell count 3,200,000, white count 9,600.

The patient was given 500 cc. of whole blood daily for the two days prior to surgery, and 250 cc. of packed red cells the morning of surgery. Just prior to being taken to the operating room his hematocrit was 37 per cent. During surgery there was considerable bleeding from the pelvic and presacral veins, and 1,500 cc. whole blood was infused. Despite this, the patient's blood pressure dropped during the procedure to 40/0 mm. Hg; this was raised with vasopressors and rapid infusion of whole blood, and at the completion of surgery it was 90/60 mm. Hg. In the recovery room his blood pressure fluctuated between 80/40 and 100/60 mm. Hg for six hours, the pulse rate from 80 to 100 per minute. Postoperative hematocrit was 42 per cent, and urine output during the first six hour period was 60 cc. In the subsequent 18 hours the blood pressure

ranged from 90/60 to 110/70 mm. Hg. The patient's skin was warm and dry, and the color was good. He was given 2,000 cc. of 5 per cent dextrose in water during the first 24 hours. His total urine output in the 24 hours was 260 cc., specific gravity 1.016, trace of albumin, 3 red and 2 white blood cells per high power field.

Dr. Baker: I thought, before we gave more information, we would ask Dr. Bernstein to discuss the problem of the patient who has had a difficult pelvic surgical procedure in which ureteral injury is a possibility, and whose urine output is diminished. The question in these cases usually is whether there was ureteral injury, unilateral or bilateral. Excluding this, what factors would be of importance in deciding whether this oliguria is temporary and of adrenal or pituitary origin, secondary to the stress of surgery, or due to nephron injury sustained during the surgery? This particular patient was in relatively good condition except for his oliguria. Our question is what to do next.

Dr. Lionel Bernstein: One starts out with a patient who has normal renal function. The ability to put out a 1.024 urine on random specimen, as this patient did, indicates a minimum of 60 per cent of normal function; so we can assume ahead of time that any subsequent azotemia is not related to chronic renal disease. We do not often have such good information preoperatively. Very often one has only the initial urine, and if the specific gravity happens to be 1.010, you have no idea as to the relative degree of function remaining. It must be pointed out that high and normal specific gravity have the same meaning: There are a good percentage of normal functioning nephrons still present in those kidneys, and we can therefore definitely exclude a significant decrease in the numbers of nephrons due to prior renal disease. It is then much simpler than when one has to consider the possibility of acute malfunction superimposed on a decreased number of nephrons due to pre-existing, longstanding renal disease. The fact that there are negative urines fits in with the concept that this is a "normal renal individual."

The first question is this: With a transient hypotension, what is the likelihood of this being acute anuria? Everyone is alert to this possibility. To me the important thing is that you do not need this kind of blood pressure drop to have acute anuria, because *cardiac output* is the important factor in the genesis of anuria.

If we assume the cardiac output to be 100 per cent of normal before surgery, we can follow it during the course of surgery. If we find the patient has a progressive fall in cardiac output due to blood loss or trauma or for some other reason, then the blood pressure gradually falls. The kidneys are partaking in this decrease too; but they are not partaking in it in a proportionate manner because, as soon as a significant hypotension develops, what had been a normal renal blood flow is now going to be low as blood is shunted to a more crucial area, for example, heart or brain. With decreased cardiac output and hypotension, the renal blood flow falls rapidly. The important thing is that the pressure may be maintained at a near normal level, despite the fact that there is a marked reduction of kidney circulation. Had there not been good vasoconstriction in the renal bed, the pressure might have fallen much more precipitously. Even in those instances where there is no clear evidence of shock, any prolonged, serious surgical procedure is a potential cause of acute anuria or lower nephron nephrosis.

In essence, to me the presence of acute anuria is indicated when there is a persistent reduction in urinary output following surgery. For how long? We are told this man put out 60 cc. in six hours. That is oliguria, but it is not of long enough duration nor severe enough to reach the conclusion that a renal insult has actually been sustained. This may still be a prerenal mechanism with shunting of blood to other areas to maintain pressure but without relaxation of the constriction. This does not necessarily imply renal tubular damage.

The thing I think most important about that 60 cc. of urine is the specific gravity. It is likely that this was fairly concentrated, and I do not mean 1.028; I would mean something like 1.018 or 1.020. This is enough to indicate that it is not acute anuria because in that case there would immediately be a change to a 1.010 specific gravity, and perhaps down to 1.008 or so. But when one is told subsequently that there is a 1.016 specific gravity, then I think that in itself makes it most unlikely that this is acute anuria. Therefore, we can continue to treat this individual as one who needs adequate fluid and colloid replacement, and with the passage of enough time, whatever

this change is which caused postoperative oliguria will simply end and urinary function will return. If, after 24 hours, the patient is not putting out urine and you are convinced that there is no reduction in blood volume and cardiac output, then you must re-evaluate the case.

Again I must return to the fact that blood pressure per se is not a good index of competency of circulation. You are more interested in the cardiac output. If it falls, kidney vasculature will constrict to try to maintain pressure. What happens is that the so-called less crucial area gets into trouble if this condition is prolonged. The fact that you have a pressure of 110/80 mm. Hg does not mean that the patient is not in a precarious shock condition. If he has marked reduction in cardiac output with extreme peripheral constriction, then the pressure is not accomplishing the essentials; there is little perfusion of certain organs, and the pulse rate is probably a much more important index. If you obtain a blood pressure of 110/80 mm. Hg and a pulse rate of 70 per minute, you can be confident that the condition is good, so far as cardiac output is concerned. But with the same pressure and a pulse of 140 per minute, you know difficulty exists. When you superimpose fever and pain, however, you get borderline states where tachycardia is not related to cardiac incompetence; so you use the urinary output as a gauge of what the systemic circulation is doing.

You can answer these questions only with the passage of time. In this special instance I think the presence of a specific gravity of 1.016 with a trace of albumin and red and white blood cells is not uncommon with any surgical procedure. These are not specific changes, and the specific gravity of 1.016 would indicate to me that it is not an acute anuria; I would feel that if the patient is kept hydrated, within 24 hours he will begin to put out more urine.

Dr. Baker: Do you think a volume of 260 cc. is alarmingly small? We teach that 400 cc. is a minimum amount for the first 24 hours postoperatively, and that the house staff should become alarmed if it falls below that figure.

Dr. Bernstein: That is not uncommon.

Dr. Robert J. Freeark, director of surgical education: Is specific gravity misleading with regard to renal function? For example, a patient with good renal function was severely dehydrated and in the face of this had a specific gravity that was only 1.010 but on final hydration was restored to 1.025.

Dr. Bernstein: This happens and I would explain it this way: We recognize that in principle there are two kinds of prerenal azotemia. We know that there is equilibrium of kidney function if the sum of the output of the nephrons equals the end products of metabolism. If 90 per cent of the nephrons are destroyed by some kind of renal disease, then, progressively, the amount of nitrogen waste being excreted is decreased so that the excretion is less than the formation of nitrogen, and the blood level will rise. As it rises, each of the remaining nephrons functioning excretes more, because if you double the blood level you double the nitrogen excretion, and then you get equilibrium again. Blood nitrogen keeps going up until there is a state of uremia. In terms of nonprotein nitrogen (NPN) it does not make any difference whether you destroy 90 per cent of the nephrons or whether you shunt them out of circulation. If you have a situation of prolonged dehydration in which the vascular constriction in the renal bed has markedly decreased the renal blood flow filtration rate, then many nephrons may not be working. The rest may be working in a fashion quite similar to that seen in chronic renal disease, and they put out urine of 1.010 with no really infallible way of differentiating from the urine of renal azotemia. When you rehydrate this individual, you return the 90 per cent of the nephrons to function and hyposthenuria no longer exists.

The second situation is seen much more commonly. If the filtration rate of each of the nephrons is reduced to 10 per cent of normal, the effect is the same as destruction of 90 per cent of the nephrons. Under these circumstances azotemia occurs because the marked reduction of all function of all nephrons is such that the total output is less and the NPN goes up. That is explained by the small amount of fluid being filtered, and there is then an excessive tendency of the nephron to retain water and sodium chloride. This concentrates the excreted urea and you get a small urinary output with a specific gravity of 1.038. You know that when you get a dehydrated patient the initial urine is commonly 1.038; normally, it is 1.022 or so. I would

suggest that there is a change and that highly concentrated urine occurs only with low filtration rate with large numbers of nephrons present. I would suggest also that a fixed specific gravity, which coincidentally is 1.010, is more commonly associated with a smaller number of nephrons, but that it does not matter whether the nephrons have been destroyed or shunted out of circulation. A mixture of these patterns will give urine in between. As long as the kidney is concentrating above 1.015, you are safe in assuming that the patient is not in acute renal failure.

Dr. Baker: In a patient such as this one we ordinarily give only dextrose and water the first 24 hours postoperatively. Would you object to a "water load" test of 0.9 per cent saline in an attempt to stimulate diuresis?

Dr. Bernstein: No. If you are considering a man who weighs 180 pounds and is in a normal state of hydration, who has minimal tachycardia attributable to the trauma he has had, whose tissue turgor is good and whose mucous membranes are moist, then he does not need anything other than water and glucose. However, if there is some doubt in your mind, give him some saline, perhaps 500 cc. This will not hurt the patient if he is normal. If he is a patient with cardiac failure, that is a different problem. But in a normal individual without evidence of heart disease, if you decide to give ½ to 1 liter of saline, it will not do him any real harm.

I want to point out that the fresh urine of acute oliguria will have a specific gravity of 1.010. When it is very scanty and heavy with blood and casts, you may get a false elevation. In this case there is no question in your mind about the pathology but you wonder whether you are measuring blood or urine. When urine goes down to 50 or 25 cc. in 12 hours it is, without question, an acute anuria.

Dr. Baker: The question has arisen as to whether solute will raise the specific gravity of urine. How much does a 4 plus glycosuria raise the specific gravity?

Dr. Bernstein: You can raise it from 1.010 to 1.014 or so. You remember that urines of diabetics or patients in uremia are still in a range close to 1.010. Albumin will raise the specific gravity to the same degree.

Dr. Baker: Do you think that systemic sepsis or allied conditions will result in acute renal failure of the lower nephron type?

Dr. Bernstein: I think there are a number of things, each of which may be enough to cause acute anuria, which are very common occurrences. It is particularly common with medical patients who have severe illnesses such as pneumonia or pancreatitis. The other complicating problem is that it is not rare to have an acute oliguria without oliguria; in other words, an individual may develop this same condition, but instead of putting out 200 cc. he puts out 800 or 1,000 cc. a day. Thus the diagnosis of acute anuria is not made because he is not oliguric. However, functionally he is doing everything that the patient with a 200 cc. output is doing. He has a progressive rise in NPN which gradually goes down, and eventually he returns to normal function. If his NPN had not been measured, you would not have been aware of the renal malfunction. In other words, his volume is about normal, but the kidney cannot concentrate, and therefore excretion is diminished.

Dr. Harold B. Haley, associate attending surgeon: We believe that acute renal insufficiency is apt to be produced in surgical cases and in patients in labor in the presence of free hemoglobin pigment and that this is an important factor. Here is a patient who had a total of six transfusions, and who may have free circulating pigment to complicate the situation.

Dr. Baker: Free hemoglobin secondary to intravascular hemolysis is probably the commonest nephrotoxin.

Dr. Bernstein: There is no question that hemolysis is a problem. It simply adds to the possibility of oliguria occurring.

Dr. Baker: We are apt, erroneously, to assume that a patient with no urinary albumin or sugar and normal blood urea nitrogen (BUN) is a suitable condidate for surgery. What is the ideal preoperative work-up from a renal standpoint?

Dr. Bernstein: If it is an elective surgical problem, then you probably have adequate time to make a few simple studies. With a normal BUN and a urine concentrated to 1.020 or more in a random specimen, you are safe in assuming that the individual has 50 per cent of renal function, probably more; such a patient should

tolerate surgery without difficulty. Phenolsulfonephthalein excretion is a good confirmatory test.

Dr. Freeark: What if the specific gravity is 1.015 on random sample?

Dr. Bernstein: This may occur in a patient who on detailed study has a urea clearance of 20 per cent of normal function with normal BUN but who is about at the point where it will not be normal if there is more reduction in renal function. This is an individual who in terms of his ability to tolerate surgery is no different from anybody else, but the thing that is different is that he will not make his own personal adjustments to water and salt intake and excrete appropriate quantities as a normal individual will; so he has to be managed more carefully. If he gets dehydrated, he cannot resorb sodium and chloride and pours these out in the urine. He has salt-losing kidneys, despite the need to retain it. The normal individual who is dehydrated and is not given saline is no problem, because in a short time he puts no sodium out in his urine. A person with renal insufficiency cannot do this; he continues to lose salt, and therefore water, and thus makes himself more dehydrated. Such a person has to be watched more carefully. If this situation is complicated by hypertension or heart failure, you have to evaluate the individual on the basis of the severity of the systemic disease.

I might say that from the urinary electrolytes alone you can draw few conclusions. But if a person is on a low salt intake and his urine is rich in sodium, there is something wrong because sodium should be reduced to almost nothing. If by surgery and postoperative suction you have created a situation where the patient is not getting sodium for several days but is still putting out urinary sodium, this also has great significance. It may indicate renal insufficiency. The point I want to make is that the presence of a certain amount of sodium in the urine does not mean anything unless you know the person's prior intake.

Dr. Freeark: I have seen two patients who were thought to have bilateral ureteral obstruction following surgery and in both there was some postoperative urinary output; it was not the abrupt cessation one would expect. There are several reasons why this occurs: (1) There may be some residual urine in the bladder before the ureters were ligated, or (2) a degree of bladder "sweat," or secretion from the bladder mucosa, or urethral glands, and (3) in the recovery room the patient is found to have only 10 or 20 cc. of urinary output, but the personnel on the ward record it as 100 or 200 cc.

In this patient I think the surgeons felt sure the ureters were free, and I think the results of devascularizing the ureters are usually not apparent for a few days. Ureters that are devascularized will transport urine for a time, and then slough, so that a total anuria will not result from stripping the ureter.

If, however, there has been ligation, there are some alternatives from the standpoint of diagnosis, and the situation becomes delicate. Primarily, your first thought is that you don't want to alarm the patient. Therefore, you get an intravenous pyelogram. Unfortunately this will not always demonstrate ureteral block. Another alternative, a more direct one, involves referring the patient to the urologist who, feeling that the patient is in bad shape, will do a nephrostomy and divert the urine. Before nephrostomy he most likely will want to cystoscope and retrograde such a patient. This would be my first choice of diagnostic procedures if there is strong suspicion of ureteral injury. You simply have to be aggressive, return the patient to the operating room, and if a competent urologist cannot pass a retrograde catheter you must assume that the ureters are interrupted.

Opinions differ as to whether you would attack the ligated portion directly or do a proximal diversion of the urine. The general surgeon prefers to go back in and see where the pathology lies, deligate or repair, and treat it definitively. The gynecologist and perhaps the urologist prefer to divert the urine proximally by nephrostomy tube because (1) many times the ligatures are of catgut, and in the 10 days it takes to resorb, continuity will be restored without having to go back in; and (2) if the ureter has been injured, it means that the anatomy was distorted, and reoperation would be hazardous and sometimes unrewarding.

Dr. Baker: As Dr. Freeark implied, no operative procedure in the face of bilateral ureteral interruption is satisfactory. The essence of these catastrophes is prevention. We always insist that our residents visualize one or both ureters in

pelvic dissections prior to completing the procedure.

An intravenous pyelogram preoperatively is of value in all colon and pelvic surgery, not only because it serves as a renal function test, but because it will show gross ureteral displacement, by a neoplasm for example.

Case 2

Dr. Leon Starkman, surgical resident: A 64 year old Negro male, admitted to the surgical service because of cramping abdominal pain of six hours' duration, without vomiting, was found on physical examination to have slight abdominal distention, hyperactive, high pitched bowel sounds, and a well healed old right paramedian appendectomy incision. His blood pressure was 190/110 mm. Hg, and a grade II soft systolic murmur was present over the precordium. He had been treated on this service five weeks previously for similar symptoms, and conservative management had resulted in a spontaneous remission. At that time his blood pressure was 220/130 mm. Hg, and electrocardiogram revealed a healed myocardial infarct. The maximum urine specific gravity was 1.010, and 2 plus albuminuria was consistently present.

After three hours of intravenous fluids and preparation, the adhesions causing the small bowel obstruction were lysed. During the surgical procedure the patient's blood pressure ranged from 110/40 to 260/170 mm. Hg. Postoperatively, after 1,500 cc. of blood and 200 cc. of 5 per cent dextrose and water, norepinephrine was required to keep the blood pressure at 130/90 mm. Hg. His pulse rate ranged from 100 to 124 per minute. No urine was excreted in the first 24 hours following surgery.

Dr. Baker: I had the dubious distinction of taking care of this patient postoperatively and spent considerable time and effort in attempting to initiate urine output. There was not much question about what had transpired during surgery. The patient had been in the hospital previously with bowel obstruction which remitted, and we discussed exploration on an elective basis at that time in light of the fact that he was a poor risk; the attending surgeon felt we should leave well enough alone. Unfortunately, the patient reobstructed, but was operated on immediately.

His course during surgery was up and down, terminating in a definite down phase. The urine output was nil for 30 hours postoperatively. Thereafter, he commenced to put out small quantitives of urine, on the third day excreting 150 cc. with a specific gravity of 1.010, 4 plus albumin, and gross blood (see table). The output started to rise on the eighth postoperative day with 950 cc. and then fluctuated thereafter. Sodium at first was 125; phosphorus was very high. Carbon dioxide combining power was normal. The clinical course was one of relative shock for a period of two days, and the patient was maintained on Levophed®; blood pressure rose to 200/120 mm. Hg, where it remained. This patient never adequately diuresed, nor did he maintain output. His NPN was high throughout the course.

Dr. Bernstein: There are some things that are very difficult to reconcile in these chemistries (see table). The sodiums are in the same range, and yet the chloride goes down to 70. Fall in the chloride means there must be some other factor at work. You would expect the carbon dioxide to go up, but it did not do so. It suggests that there is something missing; actually, there has to be something in addition to make up the difference. When you have an NPN of this range, you expect the phosphorus and other things will add 10 mEq., but there are 20 mEq. not accounted for. The only thing that is suggested is that he had some ketosis. He could then have developed that amount of ketone bodies in the serum.

Dr. Baker: Could a laboratory error have made this difference?

Dr. Bernstein: There are too many determinations to assume that. When you get all these chemistries the purpose is to see if they jibe. If they do, assume they are correct. If not, some other factor is at play. This man was on suction, and the low chloride is probably due to that. But what were his kidneys doing? Immediately after surgery, he had an NPN of 59 and creatinine of 5.2. This was before he was in the acute, prolonged, dehydrated state of bowel obstruction.

You can estimate it this way: Suppose an individual has a normal NPN, and assume 100 per cent of normal function. Then if you take him to surgery and remove both kidneys, he has 0 per cent of renal function. But his NPN will not rise for some time, for if you have 0 per cent of

renal function that will have to be present for a certain period of time before the NPN becomes elevated. That is why a patient will have a normal NPN after surgery. It is only with time that is rises as more and more of these end products are poured into the body fluid and excretion is not occurring. A creatinine of 5.2 means that this man had to have renal insufficiency for some time *before* he came to surgery, because there was not enough time between surgery and those chemistries for the accumulation of NPN and creatinine. Therefore this occurred unrelated to the surgery. In the absence of an acute process, this is routine evidence of borderline renal function or early uremia. It indicates that the patient has only 15 per cent of normal function, 85 per cent having been destroyed by some chronic renal disease. So at this time the urine probably had a specific gravity of 1.010, and this should alert one to the presence of renal insufficiency. It does not always mean actual renal insufficiency, because if one of us drinks enough water to dilute our solids, we will have a specific gravity of 1.010. But consistent 1.010 is the evidence of renal insufficiency, and it means the individual has had destruction of all these nephrons; that he had only a borderline number working without any impairment from the surgical procedure.

Suppose now you superimpose a shock state on this renal structure. Initially, the patient will develop the same kind of response that a normal person does. His renal blood flow will be further reduced, and he will have immediate renal insufficiency, whereas the normal individual has to be severely dehydrated to reduce his function this much. In the normal person dehydration may shut out only 50 per cent of nephrons; but when a person starts out with only 15 per cent of function and you reduce renal flow by any process, then the filtration rate will go further down, perhaps to a point where only 5 per cent of the nephrons are working.

The other possibility is that the patient does have an actual acute anuria of the remaining nephrons. Those 15 per cent of nephrons don't know that the other 85 per cent are destroyed; so they respond in the same fashion as in a normal individual with resulting acute anuria. The patient's subsequent diuresis represents a very good urinary output; 500 cc. would be equivalent to a 4-liter output in a normal person, so I think that it is probable that this is prerenal azotemia superimposed on renal azotemia and that the fluctuation represents ability to get some response to therapy but it is not enough to overcome the azotemia. I would say that he must have had prior chronic renal disease.

When you have a patient like this you avoid surgery if possible. If it is necessary, proceed; but this is the kind of problem that is hard to manage because he does not have the flexibility to adjust his output.

Dr. Freeark: This man needed elective surgery in the first place. In any patient who has a potentially acute problem, it would be far better to do elective surgery, not done here, than to let him get into an emergency state.

Dr. Bernstein: That is true, but it is a matter of judgment. This patient was never a good surgical risk under any circumstances.

Dr. Baker: What is the significance of hyperphosphatemia? Does the phosphorus itself act as a toxin to the remaining nephrons or to other organs?

Dr. Bernstein: No. This is an end product of metabolism being formed more rapidly than it is excreted so that it accumulates. When high serum phosphorus occurs, a low serum calcium results; then the problem of tetany may be present, as sometimes occurs in uremia, but you do not get a pharmacologic effect as you do with potassium.

Question: Can any therapy be directed toward reduction of renal vasoconstriction?

Dr. Bernstein: The appropriate treatment is directed toward the reduced cardiac output. That is the correct way to relieve the constriction. I expect also you may have some question about Levophed, which causes intense peripheral constriction and can reduce renal blood flow and aggravate the situation. This is the reason why epinephrine has not been used, because it was found to reduce the flow to given areas. There is no question that Levophed is of value, particularly in myocardial infarction.

Dr. Freeark: What is its value then with regard to the kidney?

Dr. Bernstein: Levophed will reduce renal blood, all other things being equal. But if an individual has no renal blood flow and you give him Levophed and the pressure goes up, he will

have some renal blood flow which he would not have had otherwise.

QUESTION: Your feeling is that this man is not in acute anuria, that he is putting out some urine. Would you push fluids to attempt to stimulate diuresis, and how much would you give?

DR. BERNSTEIN: You determine that by the urine output, because he cannot survive without a urinary output of 2 liters. You give him one liter a day, and he will go into uremia because he cannot put out enough nitrogen in the face of a fixed specific gravity. Without seeing the patient, it is a little hard to answer your question; but my attitude is to push as hard as you can because, if you do not give him fluids, he will die. If you do, and he drowns, he may die, but occasionally the patient will survive by diuresing. If you had not given this man saline, he might have died drier, but I don't think that is important. Caution and judgment must be applied, but I would have attempted to force him to diurese.

QUESTION: Besides the artificial kidney, is there any other method of treatment in a problem like this?

DR. BERNSTEIN: I don't know about the value of dialysis, in general. I would recommend the fluids that are deficient in that patient. If he has low electrolyte-containing fluids, then replenish with electrolyte-containing fluids. His reduction in renal blood flow probably means reduced extracellular fluid volume, so to give water alone will not help. Once you are convinced that the patient is adequately hydrated and he is still putting out small amounts of urine, then at that point you are forced to conclude that the patient is in acute anuria and a change in therapy is indicated. The specific therapy must be tailored to fit the patient.

Summary and conclusions

1. The hallmark of acute postoperative or posttraumatic renal failure is a falling urine volume despite accurate and adequate restoration of blood and body water volumes to normal. This must be differentiated from the physiologic response to trauma of moderate oliguria and water retention, and that of adrenal and /or pituitary origin.
2. The physiologic response to trauma (surgery, e.g.) involves a phase of posttraumatic antidiuresis of from 12 hours to four days. At its peak the urine output will rarely drop below 300 cc./24 hours; outputs of less than 300 cc. per day are usually on the basis of oliguria. A "water load" of 1,000 cc. 5 per cent dextrose in water given rapidly intravenously should result in an immediate increase in urine volume, despite physiologic antidiuresis, if renal function is adequate.
3. Some of the most important information required about a candidate for surgery is a preoperative assessment of renal function, or the detection of the presence of only "a few functioning nephrons." A patient who has only 25 per cent of nephrons functioning will have a normal BUN and creatinine.
4. The most useful screening tests, preoperatively, for renal function are:
   a. Ability of kidneys to concentrate to a specific gravity of 1.025 or more.
   b. PSP excretion (normal greater than 30 per cent in 15 minutes).
   c. Urea clearance (normal greater than 70 per cent).

   Adjunctive tests of screening quality are
   a. NPN or BUN, and creatinine
   b. Microscopic urinalysis
   c. Intravenous pyelography, where indicated
5. Total anuria, postoperatively, with no output, is the result of
   a. Unremitting shock
   b. Bilateral ureteral occlusion
   c. Severe transfusion reaction
   d. Embolic renal artery occlusion
   e. Acute, severe cardiac failure
   f. Removal of only functioning kidney
6. The vast majority of patients treated for acute renal insufficiency have suffered one of the following conditions:
   a. Surgery or trauma with hypotension
   b. Incompatible blood transfusion
   c. Obstetric complications with shock
   d. Severe desalting water loss
   e. Acute sepsis with prolonged hypotension
7. The causes of death in the first 5 to 7 days of posttraumatic renal insufficiency are
   a. Overadministration of fluid or blood
   b. Overwhelming infection

   The lethal triad in acute renal failure is
   a. Hyperkalemia (*continued on page 292*)

The View Box

Franz Gampl, *M. D., Chicago*



This 60 year old, white female was admitted because of constipation and loss of appetite and weight (15 lbs. in the last 6 months).

The physical examination revealed a chronically ill patient with considerable abdominal distention. Pulse: 80/min. regular, blood pressure 124/60, respiration 18/min. regular.

Examination of the abdomen showed distention and tenderness in the right lower quadrant. The bowel sounds were hypoactive to absent.

A flat plate of the abdomen was made.

Diagnosis: Bowel obstruction?
Paralytic ileus?
Perforated viscus?
Acute pancreatitis?

Turn to page 294 for correct diagnosis.

This month we are introducing, as a new feature in The Journal, The View Box to allow our readers to test their own diagnostic acumen. Roentgenograms and copy are being prepared by Dr. Franz Gampl, attending physician in the department of radiology at Cook County Hospital.

Each month he will select a current case of general interest to the practicing physician. Some may be among those shown for one week at the entrance to the physicians' cafeteria at the hospital. While physicians there must wait until the following week for the correct answer to the diagnosis, our readers may turn to a designated page in each Journal and find it.

We hope you will enjoy this feature and profit from it. Comments are welcome. *The Editor*

Postoperative Oliguria (*continued from page 291*)

b. Acidosis
c. Hyponatremia (often dilutional)

The fatal event in this triad is cardiotoxicity, usually manifested as arrhythmia, then arrest.

8. Treatment of posttraumatic renal insufficiency consists of
   a. Restriction of fluid
   b. Control of infection
   c. Glucose, fat administration ("protein-sparing")
   d. Insulin and glucose
   e. Cation-exchange resins (ammonium-sodium cycle) to reduce potassium
   f. Gastric, peritoneal lavage
   g. Hemodialysis

"D.S.R."—A Diagnostic Triad Of Coloproctology

Edward J. Krol, M.D., *Chicago*

The practice of surgery, or any branch of medicine, requires the utilization and exploitation of every possible and practical means of diagnostic acumen and armamentarium to arrive at the cause of the patient's disability. Then, and then only, can proper treatment be instituted to lower the mortality and morbidity.

The following "Diagnostic Triad," "D.S.R."—namely digital, sigmoidoscopic, and radiographic examinations of colon, if followed in this respective order, will do much to lessen diagnostic errors and embarrassments and furnish more accurate and definitive diagnoses.

Review of current literature, American and foreign, reveals that a digital anorectal examination will lead to a proper diagnosis in 75 to 85 per cent of the carcinomas.

Sigmoidoscopic examination will give similar results in 80 to 90 per cent of carcinomas of the large intestine. Since roentgenographic examination in this area is highly inadequate, sigmoidoscopic examination is, therefore, the only means of diagnosing lesions high in the rectum and low in the sigmoid.

Colonic radiography should be performed by a competent and trained roentgenologist with the ability to recognize small lesions. This usually means the use of double enemas, thick and thin, (and both with air contrast). He must also examine every inch of the palpable colon fluoroscopically under pressure. Such examinations will lead to proper diagnoses in 85 to 95 per cent of lesions of the colon above the rectosigmoid.

Since the components of the "Diagnostic Triad of Coloproctology" are so readily available, there cannot be any acceptable excuses for their omission in part or in toto. Failure to utilize the triad, especially in the presence of rectal bleeding in the older age group, is to be condemned. Proper and adequate treatment cannot be instituted without proper and adequate diagnoses.

Department of surgery, Stritch School of Medicine, Loyola University, and chairman, department of surgery, Holy Cross Hospital, Chicago.

Delayed medication

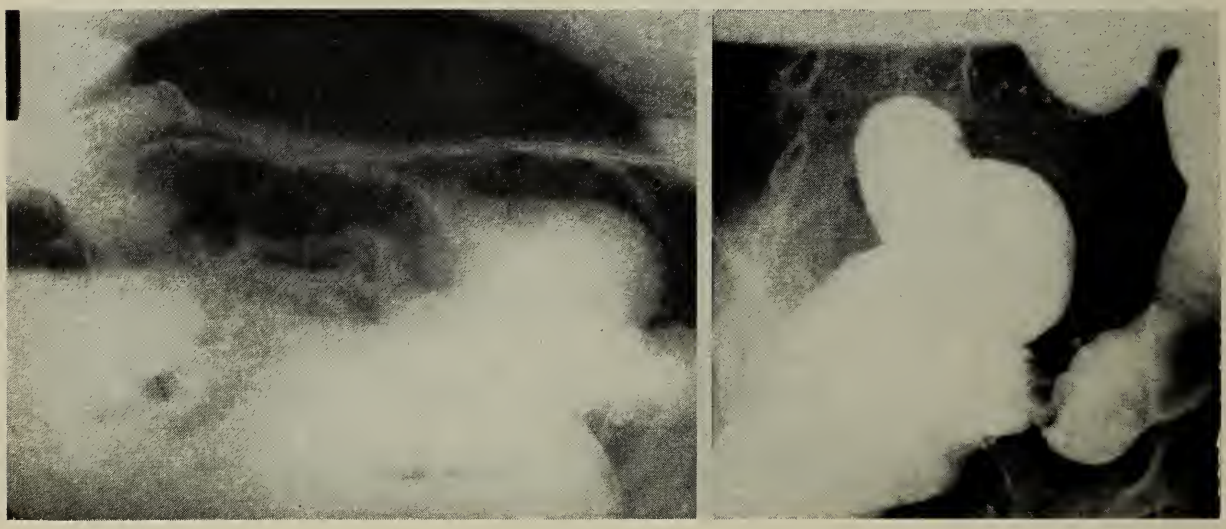
Physicians want to see that their patients get medication as economically as is consistent with good quality. It is only proper that they should. Economy, however, is not the only consideration that must be taken into account in the treatment of illness by the use of drugs. The time element and the assurance of proper handling are, in most cases, considerably more important to the physician and the patient than the spurious 'savings' (which, if any, are small) that might be offered by the mail order mechanism. From the standpoint of the physician — and the patient — the mail order prescription schemes have some serious disadvantages about which he — and his patient — should be informed. *H. C. McAllister. Mail Order Prescription Services. North Carolina M. J. September 1960.*

The View Box—diagnosis and discussion (*continued from page 292*)

The diagnosis of perforated viscus is born out by the appearance of the walls of the large and small bowels indicated by arrows in the flat film. Large amounts of air in the free peritoneal cavity will separate the bowel loops so that not only the inner but also the outer wall can be visualized. This sign is diagnostic of free air in the abdominal cavity on a plain recumbent film.

Subsequent lateral decubitus films demonstrated a large amount of air in the abdomen.* A cecostomy was done for the perforated cecum, which was secondary to a large bowel obstruction caused by an annular carcinoma of the sigmoid. This carcinoma was resected in a second stage procedure.

*Lateral decubitus views should always be included in the radiographic examination of an acute abdomen. They are obtained by positioning the patient on his left or right side, the x-ray beam parallel to the table top.



Nervous in the service

Among the individual psychoneuroses, anxiety reactions are responsible for the greatest manpower losses, in duty days lost for medical reasons, from year to year. This study indicates that many inductees with anxiety reactions were able to complete basic and advanced training and serve successfully in the continental United States and in all major overseas areas with all branches of the Army in a wide range of individual military jobs. *Brig. Gen. T. C. Bedwell, Jr., USAF, MC. Peacetime Nuclear Weapons Incidents. U.S. Armed Forces M. J. Anxiety Reaction. September 1960.*

Kangaroo meat

Pennsylvania is making an effort to keep Australian kangaroo meat out of bologna and other foods for human use. The attorney general claims there is evidence that 1,000 tons of "unfit" kangaroo meat has been shipped into the state, and a 2½-ton import is under embargo in Philadelphia. Kangaroo meat does not come under the U.S. Department of Agriculture Meat Inspection Act. Pennsylvania claims the meat is not inspected, properly cleaned, or refrigerated in Australia, and is not identified as kangaroo meat in the label. *Signs and Symptoms. Pub. Health Rep. August 1960.*

CASE REPORTS

Duodenal Obstruction Due to Gallstone

Richard C. Powers, M.D., and Charles H. Carroll, M.D., *Elgin*

The term *gallstone ileus* usually refers to obstruction of the large or small bowel secondary to a gallstone which has passed into the bowel through a cholescysto-enteric fistula. The authors recently encountered a problem related to this process, somewhat different from the usual pattern, and this prompts the present case report.

Bartholin[1] is credited with the first description of perforation of the gallbladder with migration of the calculus into the small bowel; this report appeared in 1654. Courvoisier[2] subsequently collected 131 cases of gallstone ileus, three of which are listed as having been in the duodenum. Wagner[3] in 1914 collected 340 cases, nine of which were located in the duodenum. In 1958 it was pointed out[4] that less than 900 cases of gallstone ileus had been reported in the entire literature. It is apparent from these figures that the incidence of duodenal obstruction secondary to the presence of a large gallstone is uncommon.

In general the incidence of small or large bowel obstruction secondary to migrating biliary calculi is quite low, 1.5% in a series of 30,508 cases of bowel obstruction[2]. Just as the incidence of biliary tract disease is commoner in women, it has also been determined that gallstone ileus is two or three times commoner in women than in men, and the average age is 64.[2] The mortality is high, the rate in several collected series of cases being from 40 to 50 per cent.[1]

History

Present illness. This 67 year old, white male complained of a vague, upper abdominal fullness and sensation of distress of two weeks' duration, relieved intermittently by belching and by self-induced vomiting. The patient denied having abdominal pain. He felt that, in spite of the presence of a sensation of abdominal fullness, there had been no visible abdominal distention or bloating. Bowel habits had been normal, with the passage of stool and gas through the rectum every one or two days without difficulty. He had no jaundice, dark urine, or light stools.

The patient had had an operation for appendicitis about 30 years earlier, with drainage from the wound site for several weeks after the operation. His health remained good from that time until 10 months prior to the present illness. At that time he developed an acute small bowel obstruction which was relieved surgically by lysis of a specific adhesive band in the right lower quadrant of the abdomen, 18 inches above the ileocecal junction. Since the appendix was still intact, it was removed at that time. The remainder of the history was not significant.

Physical examination: The patient did not appear to be acutely ill when first examined. He was moderately dehydrated but had no unusual pallor or icterus. The chest had an emphysematous configuration but was otherwise negative, and the heart was normal. The abdominal wall was scaphoid and showed no evidence of distention and exhibited two well healed scars in the right lower quadrant without evidence of herniation. The bowel sounds were normal. There was no involuntary guarding of the abdominal musculature and only slight tenderness in the upper portion of the abdomen. There was no abdominal mass, and rectal examination was negative.

Appreciation is expressed to the Research Fund of the Sherman Hospital, Elgin, for aid in publication of this case report.

Hospital course: Scout films of the abdomen taken at the time of admission had revealed only the presence of a considerable amount of fluid and retained food in the gastric pouch, with considerable gastric dilatation. Initial therapy was directed at gastric decompression and recovery of fluid and acid-base balance. After three days of gastric decompression, upper gastrointestinal x-rays were made. There was an obvious retention of 98% of the barium within the stomach after four hours. A small amount of barium did pass through the pylorus into the duodenum, but it was difficult to interpret the findings at the time of this examination. In retrospect, it is possible to outline an ill-defined, space-occupying defect in this area (Fig. 1). Because of the unremitting pyloric obstruction, laparotomy was carried out five days after hospitalization. A huge gallstone was found in the first portion of the duodenum, completely obstructing the outlet of the stomach. A sinus tract of considerable diameter communicated from Hartman's pouch of the gallbladder directly into the first portion of the duodenum. The common bile duct was not directly visualized, but palpation failed to reveal the presence of other calculi.



Figure 1. X-ray showing retention of barium in stomach and a space-occupying defect in the duodenum.

The surgical procedure consisted of extraction of the calculus through a duodenotomy wound, insertion of a cholecystostomy tube for decompression of the gallbladder, and gastroenterostomy to insure nutrition. The postoperative course was uneventful until the ninth day when the patient inadvertently pulled out his decompressing cholecystostomy tube. Gastrointestinal feedings had been tolerated from the fifth postoperative day and removal of the tube did not materially affect this initially. On the seventeenth postoperative day, the patient experienced a transient episode of repetitive vomiting, which subsided after 24 hours. The further course was uncomplicated. Follow-up examination revealed primary healing of the wound without herniation, the cholecystostomy drain site had closed spontaneously without further problem, and the patient was without symptoms and in a good state of nutrition. In view of the absence of other calculi at the time of surgery, no further procedure is anticipated.

Comment

The diagnosis in this instance should have been made preoperatively, but, frankly, the thought never occurred to us. Rigler[5] described the classical diagnostic x-ray critera in 1941: (1) air or contrast medium in the biliary tree; (2) direct visualization of the stone or sometimes indirect visualization by contrast medium; (3) change in position of a previously noted calculus; and (4) roentgen evidence of partial or complete bowel obstruction. Re-examination of the pertinent preoperative x-rays, in view of the findings at surgery, reveal that three of the critera established by Rigler had been satisfied. Barium can be seen entering the fistula into the gallbladder, the calculus stands out clearly, and the gastrointestinal tract is obstructed at the duodenum. (Fig. 1). The enormous size of the calculus is seen in figure 2.

Numerous articles upon this subject have detailed the important features of management. As in most instances of illness occurring in the older age group, preoperative preparation and supportive care are important. In this instance, establishment and maintenance of fluid balance and acid-base balance were paramount, thus bringing the patient to surgery in optimum general condition. The early decision for laparotomy avoided further nutritional deficit. Surgical man-



Figure 2. Huge gallstone that obstructed duodenum. Bowel resection was unnecessary.

agement consists of removal of the stone and resection of that portion of small bowel with a compromised vascular supply. In the case of the present patient, it was felt that simple removal of the obstructing gallstone was all that was necessary to re-establish continuity. The duodenum itself was not badly damaged, beyond some superficial ulceration of the mucosa; therefore, simply closing the duodenotomy wound was all that was deemed necessary locally. A Foley catheter was inserted into the fundus of the gallbladder to decompress the biliary tree proximally and provide a pathway by which structures could be subsequently identified should secondary biliary tract procedure be necessary. Although there was no reason to suspect that the small bowel would remain obstructed by edema where the gallstone lay, it was felt necessary to decompress the stomach by gastroenterostomy, and, in view of the postoperative course, this appears to have been the correct thing to do.

The second direct surgical consideration is that related to the biliary tree. Recommendations are made, when necessary, for secondary operations on the biliary tree after recovery from the primary procedure. Cholangiography carrried out postoperatively via the cholecystostomy tube failed to show the presence of any residual calculi either in the gallbladder or in the biliary tree. Therefore, any further surgery would seem unnecessary, and it is the opinion of the authors that the sinus tract will probably become obliterated. Lack of further symptoms has borne out this opinion postoperatively.

The prognosis in this instance should be good. The authors do not plan further surgery unless cholangitis, jaundice, or a calculus develop.

Summary

A case of duodenal obstruction secondary to a large gallstone is presented.

REFERENCES

1. Rogers, F. A., and Carter, R.: Gallstone Intestinal Obstruction, California Med. 88:140-143, 1958.
2. Camacho, E., Whitcomb, J. G., and Evans, D. M.: Gallstone Ileus, Henry Ford Hosp. Med. Bull. 5:345-355, 1957.
3. Wagner, A.: Ileus durch Gallsteine, Deutsche Ztschr. Chir. 130:353, 1914.
4. Rogers, F. A., and Carter, R.: Recurrent Gallstone Ileus, Am. J. Surg. 96:351-356, 1958.
5. Rigler, L., Borman, C., and Noble, J.: Gallstone Obstruction; Pathogenesis and Roentgen Manifestations, J.A.M.A. 117:1753, 1941.

Epidemic of Stiff Neck

In the autumn of 1958 and again in the late summer of 1959 a small epidemic of acute myalgia, principally affecting the trapezius muscles, occurred among nurses at this hospital. In all, 13 nurses reported sick — 7 in the first epidemic and 6 in the second. The total nursing staff at the main hospital numbers about 725, so the attack-rate sems very small. Inquiries among the nurses suggests, however, that many others were affected during the relevant periods but did not consider their symptoms severe enough to seek medical advice.

All except 1 of the 13 nurses who reported sick were admitted, and the condition was studied more fully than appears to have been possible before. *D. M. Davies. Epidemic Cervical Myalgia. Lancet. June 11, 1960.*

Idiopathic Hypoparathyroidism:

Report of a Case

Sophie J. Presley, M.D., and Jerome T. Paul, M.D., *Chicago*

Idiopathic hypoparathyroidism is a relatively rare disease which may present itself with a number of varying signs and symptoms. More common among these are tetany, convulsions, muscle cramps, parasthesias, mental changes, vomiting, constipation, soft tissue calcifications, cataracts, dental defects, and ectodermal changes involving the hair, nails, and skin. It must be differentiated from pseudo-hypoparathyroidism, a similar condition in which there is a lack of end organ response to parathyroid hormone and which may be associated with some dyschondroplasia, especially of the metacarpals and metatarsals.

The subject of idiopathic hypoparathyroidism has been extensively reviewed in recent years. Some of the most comprehensive reviews have been contributed by Steinberg and Waldron[1] and Bronsky et al[2]. The association of idiopathic hypoparathyroidism with insufficiency of other endocrine glands is even a rarer situation. A limited number of cases have been reported[3-8]. It is the purpose of this paper to record a case of idiopathic hypoparathyroidism associated with hypothyroidism.

Case report

This twenty year old, white male was in good health until the age of thirteen, when he began to have "epileptiform seizures" described as one to two hour episodes of muscle spasm of his hands and feet. There was no history of convulsions or of thyroid or neck surgery. His past and family history were negative. An electroencephalogram revealed a moderately slow abnormality, and spinal fluid analysis was within normal limits. Dilantin® sodium was prescribed with some improvement.

In 1954 the patient was hospitalized for an extensive study because of an early cataract of his right eye and a positive Trousseau sign in addition to the above history. Physical findings were otherwise normal except for poor dentition. X-rays of the skull, chest, and right femur were normal except for the presence of supernumerary teeth on the skull films. Blood counts and urinalysis were also normal. Serum calcium was 4.8 mg. %, inorganic phosphorus 10.4 mg. %, alkaline phosphatase normal, blood urea nitrogen 11.8 mg. %, and CO_2 combining power 60 vol. %. A flat plate of the abdomen was negative. A diagnosis of idiopathic hypoparathyroidism was made and the patient placed on five tablets of calcium gluconate and fifteen drops of dihydrotachysterol daily orally with good results.

The patient was first seen in the Metabolic Clinic on March 22, 1957, at which time he had no complaints. Examination revealed a well developed, well nourished, healthy appearing eighteen year old male. Blood pressure was 120/84, and the pulse was 84 and regular. A cataract was present on the right eye, but vision was normal bilaterally. There were upper and lower partial dentures. The Chvostek sign was positive, but the Trousseau sign could not be elicited. An electroencephalogram revealed a moderately abnormal tracing with few bursts of slowing and spike-like activity, maximal in the left temporal area. Skull x-rays showed calvarium

From the department of medicine, University of Illinois College of Medicine, and the Research and Educational Hospitals, Chicago.

thickness exceeding the upper limits of normal in the parietal region with slight generalized demineralization. A small density lying 3 cm. above the dorsum of the sella was thought possibly to represent a small calcification. No other abnormal intracranial densities were visualized.

Examination at the Eye Clinic showed his vision to be 20/30 bilaterally. The fundi were normal and bilateral cataracts were present. X-rays of the chest were negative. Bone x-ray revealed normal long bones of the upper and lower extremities. An intravenous pyelogram showed an essentially normal urinary tract. The hemoglobin was 14.3 Gr., hematocrit 47%, erythrocytes 4,600,000, leukocytes 5,750 with a normal differential count. The calcium was 3.2 mEq./l., inorganic phosphorus 3.5 mEq./l., serum albumin 4.7 Gm. %, serum globulin 2.3 Gm. %, uric acid 2.4 mg. %, nonprotein nitrogen 32 mg. %, fasting blood sugar 80 mg. %, cholesterol 198 mg. %, alkaline phosphatase 4.9 Bodansky units, and serum chlorides 104 mEq./l. A 17-ketosteroid level in a twenty-four hour urine specimen was reported as 4 mg. The basal metabolic rate was minus 16, and a repeat test one month later was minus 14. In June, 1957, a radioactive iodine uptake study showed a value of 21%, and a third basal metabolic rate was minus 28%.

It was felt that clinical and laboratory findings were indicative of idiopathic hypoparathyroidism and hypothyroidism. His medications were increased to 9 Gr. of calcium gluconate daily and fifteen drops of dihydrotachysterol twice daily with the addition of 1 grain of thyroid extract daily. When the basal metabolic rate of minus 28% was obtained, the thyroid extract had been inadvertently omitted for about six weeks. The patient was observed in the clinic at one to three month intervals and remained asymptomatic. His serum calcium varied from 3.2 to 3.8 mEq./l and the inorganic phosphorus from 3.2 to 4.0 mEq./l. (table 1).

TABLE 1—Serum Calcium and Phosphorus

Date	Ca (mEq./l.)	P (mEq./l.)
3-29-57	3.2	3.5
5-3-57	3.4	
6-25-57	3.6	
11-29-57	3.2	3.7
1-6-58	3.2	4.0
3-24-58	3.8	3.2
4-27-58	3.7	3.4
9-5-58	3.6	3.4
12-12-58	3.2	3.4
1-15-60	3.6	3.5

Discussion

Essential criteria for the diagnosis of idiopathic hypoparathyroidism, as stated by Drake et al[9], are a low serum calcium, high serum phosphorus, absence of renal insufficiency, x-ray evidence of normal bone structure, and chronic tetany. In addition, other causes of hypocalcemia such as chronic diarrhea or steatorrhea and of tetany, like alkalosis, must be eliminated in considering basic parathyroid insufficiency.

In a recent review of the literature, Bronsky[2] analyzed the incidence of various symptoms and signs in 50 cases of idiopathic hypoparathyroidism. He found a high incidence of tetany (76%) and convulsions and a moderately high incidence of muscle cramps, twitching, stiffness and pain, laryngeal spasm, and mental changes. Among clinical signs, ectodermal changes of the hair, nails, and skin (52%), cataracts (48%), and basal ganglia calcification (28%) were most prevalent in the cases reviewed. Sex distribution was equal. The onset of symptoms occurred at ages one to ten in 58 per cent of the cases, with the remainder up to age 54.

The subject of this report fulfilled all of the above listed criteria for the diagnosis of idiopathic hypoparathyroidism. Symptomatically he manifested only chronic tetany. Of the various clinical signs, he has bilateral cataracts without impairment of vision, supernumerary teeth, probable intracranial soft tissue calcification, and poor dentition. The Chvostek sign was intermittently positive, but the Trousseau sign was never elicited.

Other endocrine disorders are seldom found in association with idiopathic hypoparathyroidism. Its association with Addison's disease has been noted by several observers[3-7] and has been reveiwed recently by Whitaker[6] and Forbes[5]. Concurrent hypothyroidism and idiopathic hypoparathyroidism is rare[8]. Basal metabolic rates of minus 16% and minus 14% were determined in our patient. After the second test, thyroid extract, 1 grain daily, was prescribed. The pa-

tient omitted thyroid therapy for a six week period at which time the basal metabolic rate was found to be minus 28%. He was returned to 1 grain of thyroid extract daily and has continued on this dosage to the present time. Under thyroid therapy the serum protein-bound-iodine was 3.6 micrograms per cent. On the basis of the basal metabolic rates and the low protein-bound-iodine a diagnosis of hypothyroidism was made in spite of the absence of characteristic clinical signs.

Summary

A case of idiopathic hypoparathyroidism associated with hypothyroidism is presented and discussed.

REFERENCES

1. Steinberg, H., and Waldron, B. R.: Idiopathic Hypoparathyroidism: An analysis of 52 cases, Including the Report of a New Case, Medicine 31:133-154, 1952.
2. Bronsky, D., Kushner, D. S., Dubin, A., and Snapper, I.: Idiopathic Hypoparathyroidism and Pseudohypoparathyroidism: Case Reports and Review of the Literature, Medicine, 37:317-352, 1958.
3. Leonard, M. F.: Chronic Idiopathic Hypoparathyroidism with Superimposed Addison's Disease in a Child, J. Clin. Endocrinol, 6:493-506, 1946.
4. Perlmutter, M., Ellison, R. R., Norsa, L., and Kantrowitz, A. R.: Idiopathic Hypoparathyroidism and Addison's Disease, Am. J. Med. 21:634-643, 1956.
5. Forbes, G. B.: Clinical Features of Idiopathic Hypoparathyroidism in Children. Ann. New York Acad. Sc. 64:432-455, 1956.
6. Whitaker, J., Landing, B. D., Esselborn, V. M., and Williams, R. R.: The Syndrome of Familial Juvenile Hypoadrenocorticism, Hypoparathyroidism and Superficial Moniliasis, J. Clin. Endocrinol. & Metab. 16:1374-1387, 1956.
7. McMahon, F. G., Cookson, D. U., Kabler, J. D. and Inhorn, S. L.: Idiopathic Hypoparathyroidism and Idiopathic Adrenal Cortical Insufficiency Occurring with Cystic Fibrosis of the Pancreas, Ann. Int. Med. 51:371-384, 1959.
8. Himsworth, H. P., and Maizels, M.: Vitamin D_2 and D_3 and AT_{10} in Congenital Thyroid and Parathyroid Deficiency, Lancet 1:959-960, 1940.
9. Drake, T. G., Albright, F., Bauer, W., and Castleman, B.: Chronic Idiopathic Hypoparathyroidism; Report of Six Cases with Autopsy Findings in One, Ann. Int. Med. 12:1751-1765, 1939.

Testing radiation exposure

One of the most practical and reliable indications of body uptake of radioactive material is from examination of urine specimens at an appropriately equipped radiochemical laboratory. Urine specimens should be 24-hour specimens. This sample is the collection of all voidings excluding the first jet of the morning of the day of collection and including the first morning sample of the second day. Instructions should be obtained from the laboratory performing the examination as to type of container to be utilized and method of preservation, if any, of the specimen. In the Air Force, samples are sent to the USAF Radiological Health Laboratory, Wright-Patterson Air Force Base, Ohio. These examinations indicate exposure only, and do not give any actual information about damage or injury. Findings of less than the threshold value indicate that no significant exposure has occurred. Findings greater than those recommended merely indicate that an uptake of radioactive material of significance has occurred.

When an actual contamination is demonstrated, urine samples should be collected from those workers who have been within the most highly contaminated locations. Random samples from persons known to have been in areas where contamination was below the permissible levels and representative samples from persons who are known to have been in completely unexposed locations should also be collected. Approximately 1 year following an accident, random samples from persons working throughout the base should be evaluted to assure that no unsuspected uptake of material is occurring. *Brig. Gen. T. C. Bedwell, Jr., USAF, MC. Peacetime Nuclear Weapons Incidents. U.S. Armed Forces M. J. September 1960.*

Prozine® in Organic Disease

Harvey Horwitz, M.D., *Chicago*

In recent years considerable emphasis has been placed on physiological response to anxiety. The effectiveness of tranquilizers in the treatment of anxiety as it appears in a variety of organic conditions has been established. Their usefulness in disease-induced anxiety has not received adequate attention. It may be so intense that it hampers diagnosis and interferes with response to specific therapy.

The effectiveness of Prozine,* a combination of meprobamate and promazine, has been demonstrated by Parks.[1] The purpose of this report is to describe the author's experience with Prozine with emphasis on its use as an adjunct to specific therapy in chronic and long term illness.

Prozine was prescribed for a series of 50 patients, 33 women and 17 men, from 20 to 80 years of age. Thirty-four of the patients had organic disease; the majority suffered from chronic or long term illness. Patients with organic disease were given the specific therapy indicated. In addition, 3 capsules of Prozine per day were prescribed for 44 patients; 4 per day for 5 patients; and 2 per day for 1 patient. The duration of therapy was one to twelve weeks; 39 patients (78%) were treated for one to four weeks.

In 47 cases a placebo identical in appearance with Prozine was used for periods of one to four weeks. If the patient had no organic disease, the usual procedure was to use the placebo first. In chronic or long-term illness the placebo was substituted after a Prozine observation period. If the contribution of specific therapy to anxiety control was questionable, Prozine therapy was interrupted for the placebo trial.

The extent to which emotional symptoms were controlled was graded as good, fair, or poor. It included the subjective response of the patient, the observation of the investigator, and comparison with response to placebo. When drowsiness occurred, it was graded 0, none; 1, slight or transient; 2, moderate but significant; 3, drowsiness severe enough to warrant discontinuation of the medication.

Prozine capsules (meprobamate 200 mg. and promazine 25 mg.) supplied by Wyeth Laboratories.

Results

Table 1 summarizes the observations of the 50 patients. Prozine controlled anxiety effectively in 47 (94%) of the patients; in the remaining 3 patients results were fair. Placebo therapy

TABLE 1.—Prozine Therapy in 50 Patients with Organic Disease

Diagnosis	No. of Patients	Control of Emotional Symptoms: Prozine Good	Prozine Fair	Placebo Good	Placebo Poor	Degree of Drowsiness: 0	1	2	3
Heart Disease	6	6			6	3	0	1	2
Hypertension	5	5			5	4	0	1	0
Obesity	5	5			5	4	0	1	0
Respiratory conditions	4	2	2	1	3	3	0	1	0
Osteoarthritis	3	3			3	3	0	0	0
Chronic bursitis	3	3			2*	2	0	1	0
Pernicious anemia	3	3		1	1*	1	0	2	0
Migraine	3	3			3	3	0	0	0
Alcoholism	3	3			3	3	0	0	0
Other	9	9			8*	3	1	4	1
None	6	5	1		6	5	0	0	1
Totals	50	47	3	2	45	34	1	11	4

*Placebo not tried in one case

benefited only 2 patients. In 2 patients with heart disease the medication was discontinued because of lethargy; another patient complained of drowsiness, but medication was continued. It is difficult in these cases to assess the degree to which the physical condition and the drug contributed to the lethargy. In hypertension without heart disease, fatigue is not an outstanding feature. In none of the 5 patients was Prozine therapy discontinued because of lethargy; only 1 complained of drowsiness. All these were relieved of tension while on Prozine therapy. In the 5 obese patients, all overeaters, with no glandular cause for the condition, tension was controlled by Prozine during dieting. The least responsive patients suffered from chronic respiratory conditions. The tension of 3 alcoholics also was controlled, and all of them reported a decrease in alcohol consumption.

One patient with peptic ulcer and 1 with no physical symptoms were unduly reactive to Prozine; they experienced lethargy while taking 2 Prozine capsules a day.

Conclusions

The results indicate that Prozine is a useful adjunct to specific therapy in organic disease, as well as an effective treatment for anxiety. Emotional symptoms were controlled with Prozine in 94 per cent of the patients; the placebo was effective in only 4 per cent.

The percentage of patients reporting drowsiness in the present series (32%) is greater than was observed by Parks (1%) or Moessner (3.6%).[2] This may be accounted for by the physical condition of the patients in the group studied. For example, drowsiness might be anticipated when tension is relieved in patients with pernicious anemia, heart disease, or chronic illness with associated insomnia. Drowsiness was sufficient to warrant discontinuation of the medication in only 4 cases. A half-strength capsule would allow the physician more leeway in regulating the dose for patients in whom anxiety is a reaction to concurrent organic disease.

REFERENCES

1. Parks, R. V.: Treatment of Office Patients with Prozine, Internat. Rec. Med. 171:678-83, 1958.
2. Moessner, G. F.: Clinical Evaluation of a Meprobamate-Promazine Combination for Control of Nausea and Vomiting in Pregnancy, West. J. Surg. 67:180-82, 1959.

Beginning in the January issue
another new feature with
a new slant

Medicine in the Out-of-Doors

a regular monthly page
by
Julius M. Kowalski, M.D., Princeton

Toxicology in a General Hospital

Eleanor Berman, Ph.D., *Chicago*

Toxicological problems are not uncommon in a general hospital. Many children, for example, accidentally ingest harmful substances. Other cases arise from the injudicious use of proprietary and even prescribed drugs. About 15 per cent of the poisoning cases seen concern poisons, self administered with suicidal intent.

To identify most poisons today, the toxicologist uses some technical facts concerning drug action, a few laboratory instruments, fairly simple analytical techniques, and his own senses: smell, sight, occasionally taste. An adequate description of a patient's vital signs: state of consciousness, respiration, breath odor, color, temperature, pupil size and reactivity, stains or corrosion about the mouth, can save innumerable hours of analysis time. For example, an individual with pin-point pupils and no response to stimuli is not suffering from an overdose of strychnine.

Simple toxicological problems solved without any involved chemical analysis are represented by the following two cases. Case No. *256008*, a sixty year old, white female was admitted in a near shock-like state. Her tongue was blackened and swollen. There were signs of corrosion about the mouth. The saliva was thick, mucoid, and when rubbed between the fingers, felt very slippery, suggesting sodium hydroxide. Nitrazine paper placed far back in her mouth registered a pH well above 8. Obviously, a strong alkali had been swallowed. Suitable treatment was instituted.

Somewhat more complex is case No. *219224* where a toxic substance could be identified through history and presenting physical signs. A three year old child was suspected of swallowing 30 reducing capsules, each known to contain amphetamine (10 mg.), thyroid (1/3 grain), and atropine (1/240 grain). When seen approximately five hours after the disappearance of the capsules, the child seemed markedly agitated. There was a deep flush beginning at the neck and spreading upwards. Pupils were widely dilated; the child's eyes appeared unable to focus. She also exhibited a profound and continuous diuresis. It was not necessary to await the results of a chemical analysis. Toxicity from ingested thyroid medication will not become manifest in a mere five hours. The clinical signs clearly indicated amphetamine and not atropine intoxication. Though both atropine and amphetamine produce a pupillary dilation and a flushed face, atropine depresses the detrusor muscle while amphetamine stimulates a diuresis. The child was sedated with Amytal®.

Department of laboratories, Illinois Masonic Hospital, Chicago.

Modern instrumentation

In most cases however, identifying toxic substances is more complex. The older, classical means of analysis consume days. Identifying a poison requires a sample size too large for practical clinical use. Also, while classical microcrystalline[1,2] tests are useful, they serve only to identify the pure substance and cannot be used for preliminary analysis. Furthermore, the older tests are not sufficiently specific, e.g., morphine and extracts of decomposed tissue can give similar color reactions.

Before the routine use of ultra-violet spectrophotometry in identifying organic compounds, any request to ascertain the presence of barbiturates in blood or urine would induce a marked anxiety in the chemist. Reactions, at best, were insensitive and confusing. Often the positive control (barbital) gave the reaction described for the negative control (water) and vice versa. Now, with relatively simple ultra-violet spectrophotometric method,[3] we can establish the presence of a barbiturate as well as indicate the quantity. The entire procedure requires approximately twenty minutes, slightly more than the time needed for determining a blood sugar level.

At the beginning of this century, it was known that certain organic compounds absorbed varying amounts of ultra-violet light at various

points in the ultra-violet speetrum.[4,5] The pattern of absorption was quite charaeteristie for any given eompound and eould be used for identifieation. Sehiller in 1937 first sueeeeded in applying sueh knowledge in identifying these eompounds encountered in toxicological investigations.[6] Compared to spectrophotometers available now, however, Schiller's instrument was crude and difficult to manage. His success arouses admiration.

Today, sensitive instrumentation easily operated helps overeome numerous obstacles presented by older cumbersome methods and the plethora of toxic agents.

The following cases are typical of toxieological problems readily solved with an ultra-violet spectrophotometer.

Case No. *215192*, a white female aged 19, was admitted unconscious. Her mother stated that after a quarrel with her husband that morning the patient swallowed all the pills she could find around the house, aspirin included. The family physician who was summoned administered 75 mg. of Demerol®, ordered a gastric lavage upon hospital admission and 1½ grains of Seconal® to be given that evening. In view of the patient's history, the wisdom of those two drug orders is highly questionable.

Results of toxieological analysis of blood and gastric contents collected approximately two hours after ingestion were as follows[2]:

	Blood	*Gastric Contents*
Salicylates	180 mg.%	40 mg.% (200 mg. total)
Barbiturates	12.5 mg.%	36.3 mg.% (182 mg. total)
Demerol	0.15 mg.%	0
Alcohol	0	0

Blood count and urinalysis were normal. The patient was awake, but drowsy, four hours after the gastric lavage. She was discharged two days later.

Case No. *217345* F.P., a white male, aged 66, was admitted unconscious, with a scalp laceration. X-ray did not reveal a skull fracture. Routine blood count and urinalysis were normal. The patient awakened the next day and was described as being "very confused." The remainder of his five day stay was uneventful. The discharge diagnosis was contusion of head with small laceration.

He was readmitted the following week via ambulance. A coherent history could not be elicited. Routine laboratory tests were normal. Except for a 1 plus Pandy test, the spinal tap was negative. He was thought to be suffering from mental deterioration. The neurologist suggested that provision be made for future eustodial care. A few days following admission, the patient developed an aeute eystitis whieh responded to treatment. No further statements were made eoneerning his neurological status.

Six months later F. P. was again admitted in a stupor. At this time the neurologist who had also seen him on his second admission requested toxicologieal studies. Routine blood eount, urinalysis, blood sugar, and nonprotein nitrogen (NPN) were all normal. No alcohol or alkaloids were demonstrated. However, the blood barbiturate level was 7 mg.%

A month following his third discharge the patient was again stuporous upon admission. Routine laboratory work was normal. The blood barbiturate level was 3.3 mg.%. He denied taking barbiturates. However, after being hospitalized for a week, his barbiturate level was still 1.2 mg.%.

Since being diseharged at his own request, this patient has not been seen.

Salicylates and narcotics

Isolation and identifieation of frequently encountered substances like bromides or salicylates should present no problem to any laboratory. The gold chloride reaction of bromides and the ferrie nitrate reaction with salieylates are definite. Even a Duboseq colorimeter would be sufficient to quantitate the amounts present. In fact, a comparator block could be used to differentiate between negligible and toxie amounts. Both procedures can be completed in less than one-half hour.

It is important that salicylate determinations be available wherever pediatric emergencies are treated. Aspirin is such a common drug, so easily obtained, that the laity does not appreciate its inherent dangers for children. We have readily trained pediatric residents to determine salieylate levels in patients admitted at odd hours.

The isolation and identification of narcotic alkaloids presents a greater problem.[7] Plasma and urine samples must be autoclaved to free the protein-bound morphine or eodeine. However, the identification of narcotic substanees in pills, capsules, and solutions is delightfully sim-

ple — merely a matter of establishing their ultra-violet absorption characteristics. For example, if mischance might introduce a few scopolamine tablets into a bottle containing morphine tablets, the identification would be very simple. Since both compounds are alkaloids, they are soluble in an acid solution like 0.1 normal HCl. Scopolamine has peak absorbance at 251.5 mμ while morphine has a peak of 285 mμ. Scraping a few particles from each tablet in question into tubes of 0.1 N HCl and reading the absorbances of the resulting solution every 5 mμ from 220 to 320 mμ would identify the tablets.

The following incident of a precipitate in a preoperative hypodermic will serve to illustrate this principle. A nurse while preparing a hypodermic containing morphine and atropine was called from the medicine room. She did not stop to lock the syringe in the narcotic cupboard. Upon her return this nurse noticed that a precipitate had formed in the syringe. Laboratory assistance was sought to explain the mystery.

Two aliquots were removed from the syringe, one was alkalinized and the other acidified. Each in turn was extracted with chloroform and the chloroform was re-extracted with acid or alkali. Ultra-violet absorption studies of the final extracts showed the syringe contained a small amount of morphine but a large quantity of Amytal. Whoever had taken the morphine understood the need of substituting another sleep-producing agent but knew nothing about incompatibilities.

Upon rare and memorable occasions an accident will uncover and solve a medical problem whose toxicological nature is unsuspected. One of the technicians determining urinary 5-hydroxyindole acetic acid (5-HIAA) excretion used as control a urine sample sent down for routine analysis. This particular patient complained only of tingling fingers and a constricted feeling across the chest. Though the history and physical findings were negative for carcinoid, her urine sample gave a strongly positive reaction for 5-HIAA. Repeated samples also gave the same reaction. No drugs known to cause this reaction had been prescribed in the hospital. The patient denied taking any medicine. Finally, after repeated questioning the patient admitted taking "pills" brought from home for her headache. These were Gynergan (ergotamine tartrate) prescribed by a physician who had died four years before her present hospital admission. After cautioning her about the dangers of refilling and taking old prescriptions without suitable medical guidance, the patient's current physician confiscated the tablets. Within three days her urine was nonreactive, and within a week the patient was symptom free.

Determining metallic poisons

Of the 540 toxicological analyses performed at Illinois Masonic Hospital over a four year period, about 80 per cent were for metals, primarily lead, arsenic, thallium. With lead determinations a quantitative result can be obtained in approximately two hours with less than 3 ml. of blood. By modifying the Hammond method[8] based on trichloracetic acid extraction, conversion to a cyanide, and lead-dithizone-complex formation, we were able to handle, easily, an average of 15 lead analyses, daily, along with the other routine and special chemistries during the summer of 1959. In determining the other metals mentioned, larger samples than we like to use routinely are necessary. It is disturbing to draw 20 ml. of blood from two year old children, while even collecting 24 hour urine samples from this group can present slight difficulties.

Problems resulting from metallic poisons are represented by this case. W. J., a four year old Negro boy, was somewhat ataxic upon admission to the children's neurology service at Cook County Hospital. A hyperkeratosis of the palms of the hands and soles of the feet was noted. While urine and blood samples were in transit to Illinois Masonic Hospital for analysis, we were notified that the child was losing his hair and eyebrows. No arsenic or lead was found in blood and urine samples, but thallium levels were 800 μg.% and 750 μg.%, respectively. Analysis repeated in 15 days showed the blood to contain 605 μg.% and the urine, 650 μg.%. Levels determined in 40 days were 350 μg.% and 88 μg.%. The child was discharged about two weeks after the last determinations, apparently asymptomatic.

In addition to the three hours spent acid-digesting the organic material present in the above mentioned samples, about three more hours were required to complete the specific reactions. Obviously, shortening the analysis time is desirable.

The comparatively recent appearance of the photomultiplier attachment for the Beckman

DU, designed to increase that instrument's sensitivity and depress extraneous emission spectra, gives promise towards utilizing flame photometry, clinically, in analyzing metallic contents of biological materials. Technical details are yet to be defined. Probably the day is not too far distant when lead, arsenic, thallium, mercury, etc. can be determined in a clinical laboratory with the dispatch that sodium and potassium are today.

Metabolic anomalies

The clinician should not minimize the role of metabolic anomalies in producing toxic states. An unknown comatose individual brought into a hospital emergency room is more often a diabetic than a drug addict. We routinely determine the blood glucose and nonprotein nitrogen whenever drug levels are requested on newly admitted comatose patients. Nor should the viral and bacterial agents be forgotten. Symptoms may be similar to those of poisons. Because of their experiences during the summer of 1958 and 1959, a few Chicago pediatricians are quite conscious of lead intoxications. However, during these last few winter months, a number of children originally suspected of having lead poisoning were later diagnosed as having measles. Recently a child with a bizarre picture plus a history of chewing on toys, newsprint, eating matches, and drinking lighter fluid was admitted. This possible toxicological nightmare resolved itself when the child obligingly broke out with chickenpox.

Summary

Toxicological problems are commonly seen in a general hospital. They are usually accidents, often involving children. Numerous poisonings can be diagnosed by an adequate history and correct interpretation of physical signs. Simple chemical tests can define the poison in many other instances. Even in complex cases, readily available instruments enable the modern clinical laboratory to identify quickly those toxic substances which by the older classical methods would require days.

REFERENCES

1. Stephenson, C. H., and Parkers, C. E.: Some Microchemical Tests for Alkaloids, Philadelphia, J. B. Lippincott Company, 1921.
2. Whitmore, W. F., and Wood, C. A.: Chemical Microscopy of Some Toxicologically Important Alkaloids, Mikrochemie, 27:249, 1939.
3. Goldbaum, L. R.: An Ultra-violet Spectrophotometric Procedure for the Determination of Barbiturate, J. Pharm. & Exper. Therap., 94:68, 1948.
4. Roche, G., and Wright, H. N.: Systematic Toxicological Analysis by Spectro photometric Methods I. Nonalkaloidal Organic Poisons, A.M.A. Arch. Indust. Hyg. & Occup. Med., 8:507, 1953.
5. Berman, E., and Wright, H. N.: Systematic Toxicological Analysis by Spectrophotometric Methods II. Alkaloidal Poisons, A.M.A. Arch. Indust. Hyg. & Occup. Med., 8:518, 1953.
6. Schiller, H.: Spektrographische Bestiminung von Alkaloiden in Leichenteiten, Deustche Ztschr. ges. gerichtl. Med., 29:104, 1937-38.
7. Woods, L. A., et. al.: Plasma Levels and Excretion of Codeine and Metabolites in the Dog and Monkey, J. Pharm. & Exper. Therap., 117:117, 1956.
8. Hammond, P. B., Wright, H. N., and Roepke, M. H.: A Method for the Detection of Lead in Bovine Blood and Liver, Univ. Minnesota Agric. Exper. Sta. Bull. No. 221, 1956.

Avoiding postoperative pulmonary disease

Posture may play a significant part in the development of (postoperative) pulmonary complications. The sitting position and slouching in a folding bed force abdominal viscera and diaphragm upward, restricting ventilation. Hydrostatic dilatation and stagnation of lower-leg veins occur on sitting and probably predispose to venous thromboembolism. It is my practice to permit the patient to walk or to lie flat in bed but not to permit him to sit.

Heavy restrictive dressings and abdominal binders are deplored as impediments to proper ventilation. The supposed support that they afford has never been demonstrated to prevent wound disruption, whereas their restrictive effect on breathing is easily seen. *Benson B. Roe, M.D. Medical Progress. Postoperative Care. New England J. Med. Sept.* 15, 1960.

EDITORIALS

Homemaker services

This month we feature the Homemaker Services on our Reference Page. This service was designed originally to keep families together when mother is ill or otherwise incapacitated. The service provides and maintains the necessary help that ill or disabled mothers need to remain comfortable and independent in their own environment. Family life continues despite the absence, illness, or incapacity of the mother. In many instances the children reap the benefits because they can continue to live at home and go to school.

The homemaker is a carefully selected, trained, mature, kind, and understanding woman between 35 and 60 years of age. She works under the supervision of the physician, nurse, or other professional people such as speech therapist, nutritionist, or social worker. Her duties vary depending upon the nature of the illness and its severity and on the availability of other family members to render personal care to the sick member. The homemaker keeps house, helps the patient with bath and other toilet duties, prepares special diets when needed, and gives prescribed medicines. Procedures requiring medical skill or judgment (such as giving injections) are not undertaken routinely by these women.

Their theme this year is "Homemaker Service — A Community Resource for Families."

The service is not free; the homemaker does not replace the mother. It does offer many persons handicapped by age or other disability the use of their residual capacity to maintain their usual role in home and community.

Screening for heart disease

For many years public health authorities have been interested in incidence and prevalence studies of various diseases. Large scale screening procedures have yielded information valuable in treatment and control of several illnesses.

Until recently, no satisfactory method of screening for heart disease had been devised. The use of the single-lead electrocardiogram was tried and found wanting. Phonocardiography also has been found unsuitable. Simple physical examination has been the most satisfactory method, but the elements of fatigue, and cost, render this impractical when applied on a mass basis.

In recent years the development of modern methods of treatment and prevention of various forms of heart disease has created a new need for a means of early detection of cardiac abnormalities.

Over the past five years a committee of The Chicago Heart Association has been engaged in the development of a new technique for screening children for heart disease. This method employs a professional quality tape recorder, to which has been added equipment developed by the committee, that renders the operation of the recorder almost completely automatic. This equipment, in its present stage of development, can record the heart sounds of 60 children per hour. About 250 children can be recorded in a normal school day. The tapes can be played back and read, for abnormal sounds, at the rate of 140 per hour. The results of the first four years of work, including verification studies, and specifications and design of the recording unit, have been published by the committee.[1]

During the school year 1959-1960 the equipment was given a field test in the Chicago Public Schools. Under the supervision of a committee representing the Chicago Board of Education, Chicago Board of Health, Chicago Medical Society, and Chicago Heart Association, the heart sounds of 33,091 grade school children were recorded and read for heart disease. The results of this project are now being studied and will be published as soon as tabulation is complete. We can say at this time, however, that the performance of the equipment exceeded all expectations. Operation was almost continuous over

the entire school year, and at no time was a tight recording schedule delayed by technical failure. Preliminary review of the data suggests that a significant number (in the neighborhood of 3 per 1,000) of previously unknown cases of heart disease were detected.

The Committee feels that this technique offers a practical way to screen large populations of school children for heart disease.

Jacques M. Smith, M.D.
Chairman, Children's Screening Committee

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[1]*Smith, Miller, Marienfeld, Hahneman and Willard; Use of Tape-Recorded Heart Sounds in Screening of Children for Heart Disease: Circulation XX, 5, p. 887, Nov. 1959.*

Criminal abortionists

The recent exposé of Chicago abortionists is a rehashing of a nasty problem that no one throughout the ages has been able to solve. Columnist Mabley blamed police, organized medicine, and the state licensing bureau. All are involved indirectly, but it is doubtful whether these groups individually or together can stop this racket. The police know who the abortionists are but seldom get sufficient evidence to lead to a conviction. The state can revoke the physician's license, but abortionists often practice without a license.

Criminal abortions are illegal and unethical in the eyes of the medical profession. The majority are not members of the medical society, but this has never discouraged them from indulging in so lucrative a practice. The bad apples include the operators as well as the more refined physicians who refer the patient, with or without splitting fees. In addition, the medical society does not have the setup to police its own ranks unless charges are brought before its ethical relations committee.

Newspapers report the news as they see or find it. In many instances, conclusions are drawn from a handful of cases. The disastrous results are emphasized to sensationalize the story, and the statistics are never questioned. Apparently the death rate and serious complications are not as high as we are led to believe.

The pregnant woman is forgotten too often in the illegal abortion. She requests it, aided and abetted perhaps by her husband or lover. Women for centuries have been seeking the help of someone to do away with unwanted pregnancies. The motives usually are powerful and compelling. Contrary to general opinion, it is not the single woman who supports the abortionist. The majority are married, possibly because more married women get pregnant than those who are single. Pregnancy in the single girl leads more often to the altar than the abortionist.

The abortionist is the other culprit. He or she is a criminal outside the law and excommunicated by the medical profession. What makes a highly educated man resort to an illegal practice? Money perhaps, but there must be another side to the story. One of the most interesting reports along this line was made by the Institute for Sex Research, founded by the late Alfred C. Kinsey.[1] Its interviewers questioned more than 18,000 men and women and acquired as subjects several practicing abortionists during the course of taking sex histories. There were only a few, but the interviewers were "impressed with their technical ability and low number of deaths and ill effects resulting from their operations." The interviewers found also that in most cases the abortionist showed a genuine concern over the plight of a woman with unwanted pregnancy. They told of an abortionist who performed 30,000 abortions without a single death, and he gave considerable evidence to support his claim. He was so concerned with these women that he attempted in vain to have a psychiatric social worker to counsel prospective abortion patients in the social and emotional aspects of their problem.

There is no doubt that a demand exists for the services of an abortionist. He may justify his existence on this account, but the criminal nature of the abortionist also creeps out when he attempts to bring the family physician into the picture through phone calls and a letter containing an unsubstantiated and unwanted cash rebate.

The referring physician may be sympathetic also with the plight of the woman who does not want the pregnancy. We question the motive, however, when he begins to split fees. He is just as guilty as though he masterminded the crime or sat in the get-away car as the lookout for a band of thieves.

More liberal abortion laws might help the

situation as well as a more widespread use of contraceptives. But changes in our mores or laws are unlikely in the light of social and religious objections to both practices. The Soviet Union had to shift its policy relative to free legal abortions because of mounting reports of undesirable side effects. There was wide sterility and libido damage as well as an adverse effect on the general health of women whose pregnancies had been interrupted. Other countries are conducting similar experiments as a form of social reform. Reasons vary from the "worn out mother" gimmick to overpopulation. Russia did it to emancipate women and to give them equal rights with men by not asking them to bear unwanted children.

Will the illegal abortion problem be solved in our generation? Possibly, considering that during the past 25 years we already have solved a host of problems that existed also since primitive times.

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[1]Pregnancy, Birth and Abortion, Paul H. Gebhard, W. B. Pomeroy, Clyde E. Martin, C. V. Christenson, New York, Harper-Hoeber, 1958.

The referring physician and the Rehabilitation Institute

Dr. Howard Rusk has stated that rehabilitation begins with the belief that the physician's responsibility to his patient does not end when acute illness is over or when surgery has been accomplished, but ends only when the patient has been returned to a productive and useful life. Rehabilitation, then, starts the moment of the acute onset or injury and extends to the point of return to the community as a functioning citizen; and it is the responsibility of the physician to guide the patient through the many different phases of his rehabilitation program.

Ideally, each physician should have readily available to him the help of the many other disciplines of medicine including the nurse, physical therapist, occupational therapist, speech therapist, social worker, psychologist, and vocational counselor. Unfortunately, it is the rare physician who finds himself in this position, and of necessity, we have had to build rehabilitation centers where these services can be grouped together for a truly comprehensive rehabilitation program.

How can we say that it is the physician's responsibility to carry his patient through the rehabilitation program and then suggest that he turn over his patient to an institution to carry out the greatest portion of this rehabilitation treatment? Just as the physician finds in his daily medical practice that he has to turn to physicians in other specialties for further consultation, so must he turn to a rehabilitation center as a group consultation service.

The Rehabilitation Institute of Chicago is a voluntary, non-profit hospital devoted to the care of patients with neuromuscular-skeletal disabilities. It functions as a service or consultant organization for physicians and health agencies in the community and accepts patients only upon medical referral. The Rehabilitation Institute can assume responsibility for the management of the rehabilitation problem only. In the case of the patient treated in the outpatient department, services can remain very limited. The diabetic amputee, for example, will continue to see his private physician for the management of his diabetic problem and at the same time can be followed at the Rehabilitation Institute for prosthetic fitting and training.

In servicing the in-patient, however, the problem becomes more complex. Here, the institute is assuming the responsibility for 24 hour care and, of necessity, the internist and other specialists on the staff must provide the daily medical management as necessary. However, any physician whose referred patient is accepted as an in-patient at the institute is automatically extended the privilege of courtesy staff appointment, the appointment to last the duration of the patient's hospitalization. The physician is then encouraged to visit his patient at the institute as frequently as he can, daily if possible, and to assist the institute physician in the general management of the case.

Recognizing the fact that it is difficult for many physicians to get to the institute to see a patient this frequently, we have had to turn to reports as the best method of communication. All physicians receive an initial report concerning their patient soon after admission; monthly notes are sent to them; and a final summary of hospitalization is sent when the patient is discharged. Let us stress that we do not feel any major decision can be reached without prior consultation with the referring physician. In this

way, the Rehabilitation Institute offers a service to the practicing physician to help him in carrying out his rehabilitation responsibilities.

If any rehabilitation program is to succeed, the referring physician must remain active. He must adequately prepare the patient for admission to such an institution, maintain as much contact as possible during the hospitalization, and have adequate reports and summaries from the rehabilitation center subsequent to discharge. Only in this way can he continue to offer the treatment necessary to keep the patient in the stage of productivity which he was able to reach through the benefit of a rehabilitation program.

Bernard J. Michela, M.D.

From the Quarterly Review of the Rehabilitation Institute of Chicago, July 1960.

Report to the people

The U.S. Department of Health, Education and Welfare was so impressed with the 1959 report of the Peoria Health Department that it was upheld as a model for other cities to follow:

"In the 1959 report of the health department of Peoria, Ill., printed in pocket size on coated paper, the frontispiece carries a sketch of the new city health center. An informal greeting, of 250 words, by Dr. Fred P. Long, director of health, is followed by eight pages of pictures of the department in action, including press and television work, classes for expectant parents, inservice training, counseling by public health nurses of mothers and the aged, school health, followup of accidental poisoning, clinics, history recording and filing, sanitation, laboratory and dental services, rabies control, and a deep bow to the clerical staff restoring their mental health over a cup of coffee.

"One page with six brief paragraphs is given to current achievements, such as a conference on emotional health in the schools and the reduction of the number of outside toilets to 26 in a community which had 3,300 when the health department was organized. The facing page looks to the future, with three items, set up in news-page form, referring to an air pollution report, a survey of the effects of fluoridation in the city, and a continuing program of immunization.

"The last page carries the local vital statistics, with a breakdown of leading factors in death and illness, and a financial statement. The inside back cover lists the names, jobs, and locations of all employees of the department. The back cover says: "Scientific progress is based on the art of knowing the changing wants and needs of the people."

"George Hensley, director of health education, lists himself in alphabetical order under administration." *Report to the People. Pub. Health Rep. Aug.* 1960.

Better prognoses for "strokes"

If cerebral arteriography demonstrates a surgically accessible arterial abnormality, or perhaps reveals a large intracerebral clot of the frontal lobe which has obliterated its own bleeding point but is threatening cerebral function by acting as a tumor, surgical treatment may radically alter for the better a previously hopeless prognosis. Even in so-called "spontaneous cerebral hemorrhage," which for years has carried a mortality rate close to 95 per cent, early diagnosis by angiography and prompt surgical intervention when indicated have successfully lowered this figure to about 50 per cent. In all probability there will always be a certain number of patients with cerebral hemorrhage for whom no definite therapy is available, but this number will become progressively smaller as routine cerebral arteriography "weeds out" those for whom specific measures offer considerable hope. *R. A. Kuhn, M.D. The Misnomer "Stroke." Am. Pract. & Digest Treat. April 1960.*

AT THE EDITOR'S DESK



How Is Your Fire Protection?

A package plan of fire insurance that includes all aspects of protection is available to physicians at moderate cost. Fees are paid on a monthly basis and include regular inspection of equipment as well. It should be beneficial for those who have never given consideration to fireproof storage of their records or the need for fire escapes and liability insurance.

The retired chief of fire prevention in New York City, James P. Ragan, spells out some of the fire hazards in a physician's office in the September issue of New York Physician. A few more come to mind.

Initial inspection includes office layout. File cabinets, furniture, and the receptionist's desk that block doorways, and flower boxes and air conditioners that block escape by window are fire hazards. So are ether and other inflammables stored in unventilated closets or near unprotected electrical equipment and areas where smoking is permitted.

Office employees are not neglected by the service. Such dangerous practices as throwing alcohol-soaked cotton balls and gauze into wastebaskets are pointed out. Employes are taught how to turn in a fire alarm, how to evacuate patients once a fire has started, the hazards of volatiles and electrical equipment, and how to operate fire extinguishers. For general purposes in a physician's office, the extinguisher that contains carbon dioxide is preferable, for it is effective, when water is not, against burning oils and chemicals. In addition, carbon dioxide does not injure rugs or furniture.

Since fire insurance should be based on replacement rather than original cost, it is reviewed and updated regularly. Liability insurance is, of course, made adequate.

Pharmaceuticals

Ditran (Lakeside) was reported to produce realistic insanity in human volunteers. It is an eight to twelve hour psychosis that is indistinguishable from the true disease.

The Lakeside Laboratories are experimenting now with two drugs to overcome the effects of Ditran. Tetrahydroaminacrin reversed the psychosis in five minutes; the other, cyclopentimine, was antagonistic and brought about substantial improvement in 50 per cent of a variety of schizophrenic patients.

Recording Reflexes

The Achilles tendon reflex is prolonged in patients with myxedema. This cannot be seen with the eye but is definite when detected with a photo-electric device — the Photomotograph (Burdick) and recorded on an electrocardiograph.

A tap on the Achilles tendon with a percussion hammer causes the foot to move, thus making a record showing the duration of both contraction and relaxation. The normal time from start of tap to one-half relaxation is 300 milliseconds. It jumps up to 485 for hypothyroidism and goes down to 235 for hyperthyroidism.

Time will tell whether the photomotograph is as practical and accurate as the BMR or PBI tests.

Prosthetic Heart Valves

"Man is one step nearer his long-time goal of replacing faulty heart structures, valves, and arteries with man-made parts," claims the B. F. Goodrich Co. They make prosthetic valves from a rubbery plastic material known as Estane.

Laboratory tests have demonstrated that cardiac valve implants in dogs were accepted by the tissues of animals throughout a series of experiments lasting up to 15 weeks. Dr. W. J. Kolff, the father of the artificial kidney, has also used Estane in the development of a plastic heart. "Man-made" has a dual connotation: Man makes some things inside the body and other things outside.

Crystal Gazing

Predictions of what physicians will be doing 10 to 100 years from now are coming in fast and furiously.

A hospital architect, E. Todd Wheeler, writing in the September Bulletin of the International College of Surgeons, sees the hospital of the future — "the day *after* tomorrow," as an entirely different place. It will disappear entirely because medical science will treat all diseases in the home. It will remain a center of treatment only for the ambulant patient. All health services will be rendered by the state in a series of 10 or 12 central points to which anesthetized patients will be sent through pneumatic tubes. Mechanical and electronic scanners will assemble and record each patient's symptoms, an IBM machine will diagnose and prescribe treatment, and an automatic therapy machine will give treatment to the patient comfortably relaxed on a continuous conveyor belt. Psychotherapy, the author predicts, may develop to the point that all treatment will be given through the psychiatrist, and the hospital, if it exists at all, will become a club.

In a fitting conclusion, he says, ". . . the most ominous portent of all is that hospitals will eventually be planned without architects and operated without doctors."

A more realistic problem centers about our growing population. Medical World News has the following to say regarding how physicians are reacting to shifts in the nation's population as shown by the 1960 census. It points out three "firm trends." (1) Physicians continue to flock to large urban centers. Population of 50 of the largest cities increased 5 per cent, but physicians practicing in them increased 23 per cent over the last decade. (2) Cities of the South, Southwest, and Pacific Coast have increased their physician population most rapidly, but the growth of cities in these sections of the country has outstripped medical growth. (3) Physicians increased in the Eastern and Midwestern cities, despite population declines in these regions. Advice to physicians: Go West (or South), young doctor, go West (or South).

Tumor Test

A more sensitive tumor skin test (TST) was reported recently in the Journal of the American Geriatrics Society by Dr. Jack G. Makari. Only 3 per cent of all patients with carcinoma showed negative results as compared with 31 per cent in an earlier study using less sensitive TST.

Clearing the Air

Several reports have appeared on anti-smog devices for automobiles. The Monoxit Exhaust Purifier embodies a unique combination of direct flame afterburner and catalytic converter in a compact, easy to install unit. It is no larger than three inches in its major dimension and is attached directly to the exhaust manifold under the hood.

The cost is $50. The Monoxit Pantex Corporation will make it available to automobile manufacturers and the public in 1961.

Anti-smog devices will be required in the Los Angeles Basin, but we wonder how long it will take the manufacturer to convince the authorities in all congested areas to pass similar laws.

Jargon

The following title is food for facetious thought: "Plastic Surgeons meet in Los Angeles October 2-7." We didn't realize that they now made surgeons out of plastic.

Scholarships Go Wasting

More than 237,000 scholarships are available to help lessen the drain on savings of families sending their children off to college, according to the U. S. Office of Education. Some of these scholarships are not even used because people don't know about them.

So, if your family income is less than 10 to 12 thousand dollars a year, by a ruling of the College Entrance Board, you may start searching for that scholarship for which your child

can qualify. You may write for information to Scholarship Service, the Register, 2020 M Street, N.W., Washington 6, D. C.

The National Defense Student Loan Program has $57.7 million in Federal funds for 1960-1961 to encourage and assist able students to continue their higher education who might not otherwise be able to do so.

The seven Illinois institutions participating in the program have been allocated $2,498,330 to meet 1960-1961 requests.

Medicine Around The World

As the world shrinks and small nations come into the limelight, the World Medical Association has gathered some interesting facts about medical practice around the world.

Guatemala with a population of 3,500,000 has 700 physicians, 500 of whom practice in the capital city. . . The Sudan Medical Association has, since that country became independent, changed its registration from that of a Trade Union to that of a socio-academic organization . . . Ghana has 219 doctors, 20 of whom are specialists, for a population of about 5.5 million . . . The Australian Pharmaceutical Benefits Scheme has been extended, imposing indirect limitations on prescribing and a cumbersome administrative process . . . Under the Japanese Health Insurance scheme the doctor receives a fee of 15 cents for a complete physical examination or a consultation.

The Safest Way

What is the safest way to travel? The Metropolitan Life Insurance Company has figured death rates per 100 million passenger miles for 1957-59 as follows:

Railroad 0.13
Buses 0.19
Domestic scheduled airlines 0.44
Passenger automobiles 1.28 (1958-59 rates)

Airlines have reduced their passenger death rates 90 per cent in the last 20 years (4.70 in 1937-39), and 75 per cent within the past 10 years in face of a volume measured in passenger miles that has more than quadrupled. Air travel now appreciably exceeds the passenger mileage on the country's railroads. On the other hand, the passenger death rates for scheduled airlines is only one-third of that in automobile travel on turnpikes, which is safer than automobile travel generally.

Gains in safety in scheduled air travel are attributed to progress in the design and construction of aircraft, thorough training for pilots and other plane personnel, longer runways, improved traffic control procedures, and more accurate information on weather conditions.

Hepatitis Incidence and Deaths

Despite the cyclic occurrence of hepatitis, which includes homologous serum hepatitis, deaths from infectious hepatitis remained relatively constant (800 to 900) from 1952 to 1958. There is no explanation for this, according to the USPHS. The number of deaths in all age groups under 45 was essentially the same throughout the period, but there were more deaths over age 44 in 1957, the low incidence year, than in 1954, the high incidence year.

The outcome in the recent increase in hepatitis will not be known for another year.

Research is Wonderful

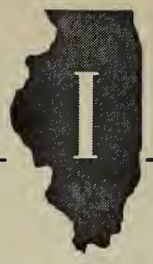
The following abstract of the article "Perception of Apparent Motion in the Common Toad" appeared in *Science*.

A simple and inexpensive apparatus makes possible the feeding of nonliving objects to the toad. The device is used to demonstrate the perception of apparent or "induced" motion. Two methods are successful: (i) toad and food moving together at a constant velocity in a stationary environment; (ii) toad and food stationary with the environment moving. The phenomena are similar to those found in human beings. *Walter Kaess and Francis Kaess. Perception of Apparent Motion in the Common Toad. Science. Oct. 7, 1960.*

Setting Terms Straight

Dr. Robert J. Huebner finally called a spade a spade when he told the American Academy of General Practice that "nonparalytic polio" is an "overused wastebasket term." The diagnosis is poliomyelitis regardless of whether the virus produces paralysis, respiratory ailments, or meningitis.

ANNOUNCEMENTS



Conference on effective medical writing

"Effective Medical Writing" will be the subject of workshop sessions on Saturday, the second day of the American Medical Writers' Association annual meeting at the Morrison Hotel, Chicago, November 18 and 19. Walter Kahoe, Ph.D., medical director of J. P. Lippincott Company, Philadelphia, will be moderator of the morning panel. Physicians participating will be W. D. Snively, chairman of the Mead Johnson & Company of Evansville, Ind., and Joseph Garland, Boston, editor of the New England Journal of Medicine.

The techniques of medical writing will be under discussion by the second panel. Physician editors participating will be Morris Fishbein, Chicago; Richard M. Hewitt, Rochester, Minn.; Walter C. Alvarez, Minneapolis; Laurence D. Redway, New York.

Opportunities for further discussion will be afforded at the table-hopping smorgasbord luncheon, one speaker presiding at each table.

Nonmembers will be charged a registration fee of $5 for the Saturday program.

At two panel discussions Friday, subjects to be discussed by authors, editors, and publishers will be "Information: What It Is and How It's Used" and "Modern Aids for Medical Communication." These discussions are open to interested persons.

Dr. T. R. Van Dellen, Chicago, will be installed as president.

College of chest physicians meeting

The American College of Chest Physicians will hold its interim session November 26 and 27 at the Shoreham Hotel in Washington, D. C. Administrative sessions will be held November 28, following the scientific sessions.

The scientific program includes symposia on Congenital Bronchopulmonary Disorders, The Role of Steroid Therapy in Chest Diseases, and Current Therapeutic Issues.

Fireside Conferences on Sunday evening and three round-table luncheon discussions complete the program.

Fellowships for foreign study

The Association of American Medical Colleges is seeking applicants for the Smith Kline & French Foreign Fellowships that enable selected senior medical students to benefit from clinical experiences and to practice preventive medicine at outpost facilities in greatly differing societies and cultures.

Application forms and brochures detailing complete information on the foreign fellowships have now been mailed to deans of all U. S. medical schools.

Last year, grants totaling some $50,000 were made to 29 students under the program. The cash awards are made from a $180,000 fund provided by Smith Kline & French Laboratories, Philadelphia pharmaceutical firm.

Fellowships are available to men and women who have completed their junior year of medical school; eligibility will continue through the senior year. Those who have started internships will not be eligible. It is expected that about 30 fellows will be named in 1961.

Applicants will be asked to present a detailed plan of work and study for the duration of the grant.

Fellowships provide money for travel costs and living expenses during the time of the student's 12 week overseas program. The amount of the grant will vary depending on the proposed program and its location. In 1959, the first year of the fellowships, grants ranged from about $1,000 to $3,000.

An A.A.M.C. Selection Committee of prominent medical educators will act on the applications in early February, and fellows will be announced in early March.

During the first year, students studied in such places as Bolivia, Republic of the Congo, Ghana, Southern Rhodesia, India, Thailand, and Java. Seventeen of the first year fellows studied at church-supported mission hospitals. The remaining 12 were stationed at government, university, and other hospitals and clinics.

Board examination

The next scheduled examination, (Part 1), written, will be held in various cities of the United States, Canada, and military centers outside the Continental United States, on Friday, Jan. 13, 1961, by the American Board of Obstetrics and Gynecology.

Candidates submitting applications in 1960 for the 1961 examinations are not required to submit case reports as previously required to complete the Part 1 Examinations of this board. In lieu of this requirement, new candidates are required to keep in their files a duplicate list of hospital admissions, as submitted with their application, for submittal at the annual meeting in Chicago should they become eligible to take the Part II (oral) Examinations.

Reopened candidates will be required to submit case reports for review thirty days after notification of eligibility.

Current Bulletins may be obtained by writing to Robert L. Faulkner, M.D., Executive Secretary and Treasurer, American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6.

AMA clinical meeting in Washington

The clinical meeting of the American Medical Association in Washington, D. C., November 28-December 1, will stress "New Developments in Old Diseases and Old Developments in New Diseases," in symposia, presentations, and discussions.

Participants will include proponents of both sides where different views exist on the management of a disease or medical condition.

All the scientific sessions will be held at the District of Columbia National Guard Armory. Starting at 9:30 a.m. on Monday and running until 11:30 a.m. Thursday, three sections in both morning and afternoon will be held simultaneously in separate rooms at the Armory. One section will be devoted to presentations of formal papers, another to panel discussions, and the third will be a symposium, all of which have question-and-answer periods. Approximately 125 scientific exhibits (over 100 exhibits in the Industrial Exhibition), medical motion pictures, and closed color television showings from Georgetown University Hospital are listed in the program.

Three scientific breakfast programs will be held on Tuesday and Wednesday at the Statler Hotel with the themes of "To Do or Not To Do" and "Problems of Management" in particular diseases or types of cases.

Pediatric residency fellowships

Wyeth Laboratories, Philadelphia, is offering 20 two-year grants to encourage qualified doctors to pursue postgraduate resident training in pediatrics. Each Pediatric Residency Fellowship carries an annual stipend of $2,400, effective July 1, 1961. Closing date for applications is November 30. Awards will be announced the first week in February.

Eligible for the fellowships are interns, physicians who have recently completed their internships, military service, or U. S. Public Health service tours, and research fellows. Recipients must be citizens of the United States or Canada and have a doctor's degree in medicine.

Fellowships will be awarded on the basis of applicants' interest in pediatrics, character, conscientious and able performance of duties, and academic competence.

Those receiving grants must serve a residency in pediatrics in a hospital properly accredited by the Residency Review Committee of the Council on Medical Education and Hospitals of the American Medical Association, the American Board of Pediatrics, and the American Academy of Pediatrics.

Recipients will be chosen by a committee composed of five eminent pediatricians whose chairman is Dr. Phillip S. Barba, University of Penn-

sylvania School of Medicine and past president of the American Academy of Pediatrics.

Applications should be submitted to Dr. Barba, School of Medicine, University of Pennsylvania, Philadelphia 4.

Film on nausea

A new 21-minute color film, "The Mechanism and Control of Nausea and Vomiting," available on a free-loan basis to professional audiences, was recently released by Smith Kline & French Laboratories.

The film is based on the findings over the past 10 years on the neurological mechanism involved in nausea and vomiting, using fluoroscopy and animation to review some of the diseased states that cause vomiting, and illustrating the roles of the gastrointestinal, respiratory, and central nervous systems in emesis. It also describes the pharmacological rationale for the use of phenothiazine drugs in the control of vomiting and discusses the drugs as antiemetic agents in therapy.

The film is obtainable through local representatives of the Philadelphia pharmaceutical firm or through the Medical Film Center, Smith Kline & French Laboratories, Philadelphia 1.

1961 Van Meter Prize Award

The American Goiter Association, Inc., again offers the Van Meter Prize Award of $3,000 to the essayist submitting the best manuscript of original and unpublished work concerning "Goiter—especially its basic cause." The studies may relate to any aspect of the thyroid gland in all of its functions in health and disease.

The essays may cover either clinical or research investigations, should not exceed 3,000 words in length, and must be presented in English. Duplicate typewritten copies should be sent to the Secretary, John C. McClintock, M.D., 702 Madison Avenue, Albany 8, N. Y., not later than Jan. 1, 1961.

International PG course

Physicians and surgeons from three nations will participate in an international clinical postgraduate program to be offered by the University of California Extension in January, 1961.

It is sponsored jointly by the School of Medicine, UCLA; Universidad Nacional Autonoma de Mexico; the University of Guadalajara School of Medicine; and the Escuela Nacional de Medicina, Mexico, D.F. Participating doctors will have an unusual opportunity to avail themselves of different types of case material in this section of the American continent.

The program, which will convene in Mexico City, continue in Acapulco, and close in Guadalajara, will be as follows:

In Mexico City January 9 through 13:

Gastroenterology and Internal Medicine, Cardiology, Pediatrics, Dermatology and Mycology, and General Surgery.

In Acapulco: January 15—Obstetrics and Gynecology;

January 17—Traumatic Surgery.

In Guadalajara: To be announced.

Requests for additional information or applications should be addressed to Thomas H. Sternberg, M.D., Assistant Dean for Postgraduate Medical Education, University of California Medical Center, Los Angeles 24.

The end of Hoxsey treatment

The last remaining major source of exploitation of cancer victims by the worthless and discredited Hoxsey cancer treatment has been eliminated by a Federal court order. "Complete and final discontinuation" of the treatment is required. This culminates ten years of almost continuous litigation.

Dr. Harry R. Taylor, who operates the Taylor Clinic in Dallas, where the Hoxsey treatment was being administered, and two members of his staff, Walter J. Williams, M.D., and Allan F. Devore, D.O., have consented to a decree of permanent injunction which orders them to stop permanently the sale of medications comprising the Hoxsey cancer treatment, according to George P. Larrick, Commissioner of the Food and Drug Administration.

Since May 1, 1957, Mr. Hoxsey has been receiving 50 per cent of the profits of the clinic, which he had owned and operated previously. It has been estimated that cancer patients paid over $50 million for the worthless treatment. In a separate supplemental consent decree of injunction, Hoxsey is ordered to cease participating directly or indirectly in sharing the profits of the operations of the Taylor Clinic.

Three lengthy court trials have been won by the government over the decade. In October, 1954, Hoxsey was permanently enjoined from sending his drugs by interstate commerce with labeling as effective cancer treatment. In 1956 seizure of half a million Hoxsey cancer pills by the government was upheld by the Federal court at Pittsburgh. The third trial in 1957 resulted in an injunction against an off-shoot, the Hoxsey Cancer Clinic in Portage, Pa., which was closed permanently in 1958 after it violated the Court's injunctive order.

Medical journal suspends publication

With the July issue the Mississippi Valley Medical Journal, official journal of the Mississippi Valley Medical Society since 1939, suspended publication. Dr. Harold Swanberg, Quincy, has been editor. The journal was incorporated in Clinical Medicine in September.

Applications for research grants

Application for grants for medical and social research in tuberculosis and other respiratory diseases are now being accepted by the National Tuberculosis Association, through its medical section, The American Thoracic Society. December 15, 1960, is the deadline for submission of applications for the grant year July 1, 1961, through June 30, 1962. For further information and application forms, write the Division of Research and Statistics, American Thoracic Society, 1790 Broadway, New York 19.

New disability provisions

Under the 1960 Amendments to the social security law recently enacted, severely disabled workers no longer need wait until age 50 to become entitled to disability insurance benefits. Any person under age 50 who has already had his social security record "frozen" because of his disability will soon receive a letter explaining exactly what should be done to secure disability benefits.

Any disabled worker under age 50 who has never applied to have his social security record frozen should contact his social security office immediately to learn whether he is eligible for monthly benefits, payable beginning with the month of November, 1960.

To be eligible for disability benefits, the disabled worker must have worked in a job covered by social security, or have been in covered self-employment, for at least five years out of the ten years preceding the date of disability.

Awards for research papers

Two cash awards for research papers are being offered to residents, interns, and senior medical students in the Chicago area by the American Medical Women's Association, Branch No. 2, of Chicago. A panel of specialists will act as judges, and the papers will be presented at the April 12, 1961, meeting of the American Medical Women's Association at the Mary Thompson Hospital. Both men and women are eligible. First prize $100, second prize $50.

Booklet for parents

The Children's Bureau has a new publication, "The Mongoloid Baby." It outlines some of the sources of help which parents can find either on a community or state basis and points out some of the ways they can help their child develop to the fullest the abilities he has. The publication is available from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., for 10 cents a copy.

New ileostomy manual

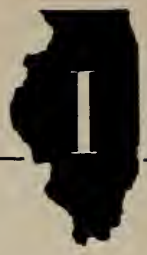
QT Incorporated, Boston, devoted to mutual encouragement and assistance of ileostomy patients, has published a fourth edition of its "Manual for Ileostomy Patients." It has been assisted by the Medical Foundation of Boston. Leading physicians and surgeons have contributed articles on the practical management of the ileostomy.

For information about it, address QT Incorporated, The Medical Foundation, Inc., 227 Commonwealth Ave., Boston 16.

TV program cancelled

CIBA has cancelled its weekly television review of medical news for physicians, "This Week in Medicine," until further notice.

NEWS of the STATE



County

Bureau

J. Harold Hopkins, who has been a physician in Walnut for the past 33 years, left general practice on November 1 to take up duties in the student health service at the University of Illinois, Champaign. He also has a teaching assignment there. This means that there is no Hopkins physician in Bureau County for the first time since the Civil War. Both his grandfather and father were physicians there. His two sons are now in residencies at Mayo's.

Champaign

The Champaign County Medical Society has approved policies for operation of the Well Baby Clinic in Champaign.

The clinic is held three mornings each month in the Public Health building and is attended by various members of the County Medical Society who are interested in pediatrics and who donate their services free of charge.

Representatives of the Department of Public Health and the Service League, both of Champaign, and the Child Welfare Committee of the County Medical Society had several meetings this last summer during which suggestions for policy were drawn up.

Cook

Dr. Bennett Heads Biological Sciences. Dr. H. Stanley Bennett, professor and chairman of the department of anatomy at the University of Washington, Seattle, and immediate past president of the American Association of Anatomists, has been appointed dean of the division of biological sciences at the University of Chicago, effective January 1. Dr. Bennett is widely known as a specialist in cellular anatomy and cytochemistry. His work with the electron microscope has yielded fundamental new knowledge of how human muscles work. He will succeed Dr. Lowell T. Coggeshall, vice president for medical affairs since March, who held the deanship for 13 years. Dr. Bennett has been a member of the National Advisory Health Council to the United States Public Health Service.

On Cultural Exchange Mission. Dr. Clifford J. Barborka, associate professor of medicine, Northwestern University Medical School, is one of five American scientists selected by the U. S. Public Health Service to survey the progress of metabolic disease research in the Soviet Union. The mission is part of the scientific-cultural exchange program under the 1958 Lacy-Zaroubin Agreement between the United States and the Soviet Union.

Honored. Dr. Russell von Milliser, professor of pathology at Chicago Medical School, was recently chosen as the teacher from whom the students have gained the most during medical training. The selection was made by members of the sophomore class. A student-faculty dinner was held in his honor in October.

Promotions. Dr Aldo A. Luisada has been promoted from associate professor to full professor of medicine at the Chicago Medical School. He first came to the School in 1950 to establish its cardiovascular laboratories, devoted to both experimental research and clinical studies and to teaching. Since then, new methods have been developed there which now make it possible to obtain important data and techniques that also permit the recording of electrocardiograms from inside the heart.

Dr. Allen L. Lorincz, associate professor of dermatology at the University of Chicago since

1957, has been appointed section head of dermatology in the department of medicine, succeeding Dr. Stephen Rothman, retired.

For Community Welfare. The Institute of Medicine of Chicago has recently established two committees: the Committee on Rehabilitation, Dr. Lowell D. Snorf, chairman, and the Committee on Alcoholism, Dr. Norman B. Roberg, chairman.

Cancer Research Training Program. A $260,000 grant for a training program in experimental cancer research covering a five year period has been awarded to The Chicago Medical School by the Public Health Service. The project will be carried on in the new Medical Research Institute now nearing completion.

The program for pathologists will be directed by Dr. Henry Rappaport. Dr. Philippe Shubik is head of the school's oncology division responsible for the new program.

Election. Newly elected officers of the Chicago Gynecological Society are Dr. Edwin J. DeCosta of Passavant Memorial Hospital, president; Dr. David N. Danforth of Evanston Hospital, president elect; Dr. Lester E. Frankenthal, Jr., of Michael Reese Hospital, vice president; Dr. John H. Isaacs of Loyola University, treasurer; Dr. Charles P. McCartney of the University of Chicago Medical Center, secretary; and Dr. Hugo C. Baum of Presbyterian-St. Luke's Hospital, assistant secretary.

Swenson Succeeds Potts. Dr. Orvar Swenson has been appointed surgeon in chief at Children's Memorial Hospital, succeeding Dr. Willis J. Potts, who has retired from that position but will remain on the surgical staff.

Dr. Swenson comes from Boston where he was surgeon in chief at Boston Floating Hospital for Infants and Children and senior surgeon at the New England Center Hospital.

Heads NU Pharmacology. Dr. Joseph A. Wells, professor of pharmacology since 1950 in the Northwestern University Medical School has been named chairman of the pharmacology department. He received his Ph.D. and M.D. degrees from Northwestern, was first a departmental assistant in pharmacology in 1938, an instructor in 1941, an associate in 1944, and was promoted to assistant professor of pharmacology in 1946. He has authored or co-authored more than 50 papers for medical journals.

Dr. Wells is past president of the Illinois section and past associate editor of the Society for Experimental Biology and Medicine, and a member of Sigma Xi and the American Association for the Advancement of Science.

Hospital Staff Election. Dr. Eugene T. McEnery, chairman of the pediatrics department at St. Elizabeth's Hospital has been elected president of the hospital's medical staff. Dr. Nicholas J. Bruno has been elected vice president and Dr. Chester F. Pollowy secretary. Dr. Eugene J. Adamski has been re-elected to a second term as treasurer.

Fulton

At the October meeting of the Fulton County Medical Society in Canton a thirty minute film, "New Concepts in Treatment of Diabetes," was shown to members.

Madison

The Madison County Medical Society has elected as treasurer Dr. Henry Malench of Edwardsville to fill out the unexpired term of Dr. George H. Vernon. Dr. Vernon has recently moved to Du Page County to become medical director of the Du Page County Tuberculosis Board.

St. Clair

The St. Clair Medical County Society sponsored an All America City Health Fair in East St. Louis October 27-29 in recognition of the award given to the city. Its purpose was to bring to the attention of the people county health services available to them through hospitals and health and welfare agencies; to promote health for individuals, their families and the communities; and to point out to young people the many careers available in the medical field.

All schools and organizations of young people were invited to arrange field trips to the Health Fair. Continuous movies on health subjects and

careers in the medical field were shown in separate rooms.

The medical society sponsored three contests for children: health exhibits (grades 7-12), poster contest (grades 7, 8, and 9), and a slogan contest (grades 1-6).

Many physicians served on committees and took active part in the fair. Dr. Matthew B. Eisele was chairman.

General

Foundation appoints executive director

Mr. Jerry J. Walsh, Chicago, formerly of Columbus, Ohio, has been appointed executive director of the Illinois Chapter of the Arthritis and Rheumatism Foundation. He has been associated with the work of the Arthritis and Rheumatism Foundation for the past ten years. For the past five years he has been the regional director for the Foundation covering Ohio, Kentucky, and Indiana.

Dr. Carnahan named Illinois GP for 1961

As we go to press we learn that Dr. William E. Carnahan, 75, of Macomb, who has practiced in McDonough County for 46 years, has been selected "Outstanding Illinois General Practitioner for 1961." He has been active in many phases of community life.

The December Journal will carry a full story.

Governors for diabetes association named

Dr. James B. Hurd of Chicago has been appointed by the American Diabetes Association as governor for Northern Illinois, and Dr. Thomas D. Masters of Springfield has been reappointed governor for Southern Illinois for the three-year term 1960-1963.

Psychiatric institute accredited

The Illinois State Psychiatric Institute has received full accreditation by the Joint Commission on Accreditation of Hospitals. The institute, newest of the state mental institutions operated by the state Department of Public Welfare, is the third fully accredited hospital in the state system. Galesburg State Research and Peoria State hospitals were previouslly accredited.

The 11-story, 434-bed, $9.5 million institute is located in the medical center at 1601 West Taylor. It links the most modern care and intensive treatment of acutely ill mental patients with training and education of medical students and other psychiatric personnel and research into the causes and treatment of mental illness. Its treatment, training, education, and research program brings the five medical schools of Illinois and the Institute for Psychosomatic and Psychiatric Research and Training, Michael Reese Hospital, actively into cooperation with the state welfare department. Separate floors are under the direct supervision of each cooperating institution.

PHS forming committee on polio control

A Surgeon General's Committee on Poliomyelitis Control to be made up of representatives of the medical and health professions and the general public is being formed by the Public Health Service. Invitations have been sent to the heads of 23 organizations asking them to designate members to serve on the committee:

American Academy of Pediatrics; American Academy of General Practice; American College of Preventive Medicine; American Hospital Association, American Medical Association, American Nurses Association; American Pharmaceutical Association; American Public Health Association; AFL-CIO; Association of State and Territorial Health Officers; Association of State and Territorial Public Health Educators; Association of State and Territorial Public Health Laboratory Directors; Children's Bureau; Conference of State and Territorial Epidemiologists; Council of State Governments; Department of Defense; General Federation of Women's Clubs; National Congress of Colored Parents and Teachers Association; National Congress of Parents and Teachers Association; National Foundation; National Health Council; National Medical Association, Inc.; Pharmaceutical Manufacturers' Association.

An agenda Committee met October 11-12 to consider both the technical and administrative problems and develop the basic agenda for the first meeting on the Committee on Poliomyelitis Control. Members represented the American

Academy of Pediatrics, American Academy of General Practice, American Medical Association, Association of State and Territorial Health Officers, Children's Bureau and the National Foundation.

The Surgeon General has invited a number of experts in the field of polio vaccines to serve as consultants to both committees.

The first meeting will probably be in December or January.

Accidental poisoning rate rises

Accidental poisoning cases among children are increasing alarmingly, according to Dr. L. L. Fatherree, director of the Illinois Department of Public Health.

Of the 4,100 cases of accidental poisoning of children up to age 12 during the first eight months of this year, almost 3,900 occurred in children up to and including age four, with the highest percentage among the two-year-olds. For the same period of 1959, cases reported were slightly more than 3,300.

About one-third of all poisoning cases in the two-year-old age group are the result of aspirin or aspirin products. Household preparations rank second.

A state-wide poison control program to save children's lives was begun in 1956 and has grown from two centers to 62. These centers for emergency treatment were set up in hospitals on a 24-hour basis; each maintains up-to-date reference materials on ingredients of hundreds of thousands of commercial products, and recommends treatment methods. The goal is to have a center within every 25-30 mile radius.

A new state law, administered by the Public Health Department, demands that all hazardous substances intended or suitable for use in households be plainly labeled to show the hazard.

Hill-Burton grants in Illinois

In Illinois to date, 86 projects at a total cost of $118,143,366, including federal contribution of $29,914,924 have been completed under Hill-Burton grants. The projects have furnished 4,684 additional hospital beds.

There are 37 other projects under construction designed to supply 2,195 additional beds, and five others for 1,395 beds have been approved.

The last two categories of projects will cost $70,161,445 with federal contributions of $15,405,809.

Baxter gives biologicals for Project Hope

A contribution of intravenous solutions that will provide approximately 1,000 patient days of care on Project Hope, a 15,000 ton medical ship that has sailed to the Far East, has been made by Baxter Laboratories, Inc.

The floating medical center has a regular staff of 15 physicians, two dentists, two pharmacists, 24 nurses, and 30 other personnel. It will first train personnel in Indonesia and Vietnam.

Cytodiagnostic training promoted

The University of Chicago is the recipient of an $11,370 grant from the Public Health Service for cytodiagnostic training of laboratory assistants.

This is one of 33 grants totalling $789,236 for demonstrations in the early diagnosis of cancer and for training laboratory assistants. The grants were awarded on the recommendation of the Advisory Committee to the Cancer Control Program and the National Advisory Cancer Council. The Cancer Control Program in the Bureau of State Services administers the grants.

December clinics for crippled children

December	1	Carlinville, Carlinville Area Hospital
December	2	Chicago Heights (Cardiac), St. James Hospital
December	6	Belleville, St. Elizabeth's Hospital
December	6	Peoria, Children's Hospital
December	7	Alton (Rheumatic Fever), Alton Memorial Hospital
December	7	Carmi, Carmi Township Hospital
December	7	Hinsdale, Hinsdale Sanitarium
December	8	Springfield, St. John's Hospital
December	9	Evanston, St. Francis Hospital
December	13	East St. Louis, St. Mary's Hospital
December	13	Peoria, Children's Hospital
December	14	Champaign-Urbana, McKinley Hospital
December	15	Bloomington a.m. (General) and

	p.m. (Cerebral Palsy), St. Joseph's Hospital
December 15	Rockford, Rockford Memorial Hospital
December 20	Effingham (Rheumatic Fever), St. Anthony Hospital
December 21	Chicago Heights (General), St. James Hospital
December 21	Elgin, Sherman Hospital
December 22	Elmhurst (Cardiac), Memorial Hospital of Du Page County

Lectures arranged through ISMS

Dr. Peter J. Talso, M.D., assistant chairman of the departments of medicine at Stritch School of Medicine, Loyola University and Mercy Hospital, spoke on cardiology at the joint meeting of the Lee-Whiteside counties medical societies in October. The lecture was arranged by the Postgraduate Medical Education and Scientific Service Committee.

Homemaker services expanding

Demand is forcing the growth of Homemaker services in Chicago. The expansion of personnel and branch offices will be made in accordance with the request of the Welfare Council of Chicago to help meet community needs. Establishing a new Homemaker Service Agency with 25 homemakers, necessary administrative staff, agency headquarters, and two district offices is estimated to cost $190,000 annually. Child and Family Services (102 years old) with its present administrative staff and headquarters can carry out this expansion, according to David J. Christensen, executive director of the agency, for $134,000, a savings of $56,000 annually. Initially it will employ 10 additional homemakers for assignment in Chicago. Then two district homemaker service offices will be established in surburban areas.

Deaths

Henry S. Babcock*, retired, Englewood, Florida, formerly of Vermilion County, a graduate of the University of Michigan Medical School, Ann Arbor, in 1891, died recently, aged 91.

Arthur R. Elliott*, emeritus member, South Haven, Mich., a graduate of Queen's University Faculty of Medicine, Kingston, in 1889, died February 6, aged 91.

Robert T. Ewan*, Lewistown, a graduate of the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1904, died recently, aged 83.

Jacob James Franklin*, Ramsey, a graduate of St. Louis University School of Medicine in 1941, died June 28, aged 52. He was on the staff of the Fayette County Hospital, Vandalia.

Ralph R. Ferguson, retired, St. Petersburg, Fla., a graduate of Rush Medical College, died October 9, aged 82. A highly regarded member of the medical profession, he was president of the Chicago Medical Society in 1926 and 1927, and headed the Illinois State Medical Society in 1932. Dr. Ferguson served on the faculty of Rush Medical College from 1904 to 1909. A native of Kellogg, Iowa, Dr. Ferguson, who was a member of the 50-Year Club, had lived in Florida since retiring from his practice as a pediatrician in Chicago 1949. He was a veteran of the Spanish-American War and World War I. He served as a medical corps major in France from 1917 to 1919.



Augustus D. Harper, Crossville, a graduate of Barnes Medical College in 1910, died September 2, aged 79.

Clara E. Holmberg*, Springfield, a graduate of Hahnemann Medical College and Hospital in 1903, died June 6, aged 82.

John B. Karr*, Chicago, a graduate of Loyola University School of Medicine in 1922, died September 9, aged 63. He was a member of the executive board of Holy Cross Hospital, the American College of Gastroenterology, American Academy of General Practice, and a past president of the Englewood branch of the Chicago Medical Society.

Harry A. Klein*, Los Angeles, formerly of Chicago, a graduate of Chicago Medical School in 1928, died June 20, aged 64. He was a member of the Chicago Society of Internal Medicine.

John Mayhue Lund*, Dixon, a graduate of the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1908, died June 19, aged 79.

Lyman S. Perkins*, Yorkville, a graduate of American College of Medicine and Surgery (Chicago Eclectic Medical College) in 1896, died August 27, aged 83. He served as deputy coroner for four years and was Kendall County coroner for 16 years.

Edward H. Seifert, Avon, a graduate of Chicago Medical School in 1918, died September 7, aged 72. He was a veteran of both World War I and World War II, heading a 3,500-bed hospital on New Caledonia and another hospital on Saipan after 1941, and held the rank of colonel when retired from service.

William Newton Sievers*, White Health, a graduate of Louisville School of Medicine in 1910, died September 17, aged 75. He was a member of the staff of the John and Mary E. Kirby Hospital in Monticello, and a former president and secretary of the Piatt County Medical Society.

Herbert E. Taylor, retired, Paradise, Calif., formerly of Chicago, a graduate of The Hahnemann Medical College and Hospital in 1914, died September 19, aged 70. He was on the staff of the Illinois Masonic Hospital.

Guy F. Turner*, Long Point, a graduate of New York University College of Medicine in 1899, died July 15, aged 84.

Charles L. Weber*, Cairo, a graduate of St. Louis University School of Medicine in 1906, died June 25, aged 77. He was past-president of the Alexander County Medical Society, medical director of the Alexander County Tuberculosis Sanatorium, a former health officer, and was a member of the medical staff of St. Mary's Hospital for many years. He was attached to a special American Medical unit that served with the Italian army during World War I and was decorated by the Italian army and government for his services.

Leo A. Zelenzinski*, Chicago, a graduate of Loyola University School of Medicine in 1927, died September 1, aged 61. He was a member of the medical staff of the Evangelical Hospital of Chicago.

**Indicates member of the Illinois State Medical Society*

BOOK REVIEWS

A Primer of Electrocardiography. George E. Burch, M.D. 4th ed. $5. Pp. 293. Philadelphia, Lea and Febiger, 1960.

This text continues as an outstanding primer for students and graduates who want to learn the essentials of electrocardiography. The beginner is introduced to all of the basic concepts, proper nomenclature, and vocabulary that are necessary for understanding the field of electrocardiography.

The writing is easily understood, and the concept of the field is practical. Explanation of theory is current, and clincal application of principals and "patterns" is very clearly stated.

This new edition is long enough to prepare the student to, as the author states, "extend his interest into the theoretic, experimental and clinical aspects of electrocardiography." This book is recommended highly.

Hugh Flack, M.D.

Industrial Pulmonary Diseases. E. J. King and C. M. Fletcher. $8.50. Pp. 269. Boston, Little, Brown and Company, 1960.

This is a collation of the presentations of a symposium held at the Postgraduate Medical School of London in September, 1957, and repeated in March, 1958. In each of the 21 chapters, eminent authorities briefly review their assigned phase of the seminar. The result is an excellent review of industrial pulmonary diseases as experienced in Great Britain. The chapters on bronchitis, coal-workers' pneumoconiosis and Caplan's syndrome (rheumatoid disease and pneumoconiosis) are particularly interesting in that these are peculiarly, but not exclusively, British. Recent studies indicate their occurrence in other industrial communities of the world. This text is a standard library reference for the industrial medical library, for the pulmonary disease shelf, and for the individual physician with interests in this area.

E. L. Walsh, M.D.

Histoplasmosis. Edited by Henry C. Sweany, M.D. $14.50. Pp. 538. Springfield, Ill., Charles C Thomas, 1960.

The editor of this classic monograph is well known to many Illinois physicians for his outstanding work in the field of tuberculosis while director of research and laboratories at Chicago Municipal Tuberculosis Sanatorium for over 25 years. The last ten years or so he has been devoted with equal energy and skill to elucidating some of the many problems connected with histoplamosis. The quality of his work is attested to amoung other things, by the winning of a gold medal for his exhibit on the pathology of histoplasmosis at an American Medical Association Annual Meeting.

This monograph is divided into 23 chapters and a summary. Each chapter is edited by a leading authority in the particular field, and the subject is superbly covered from the history of histoplasmosis to the place of histoplasmosis in the present-day practice of medicine. Each chapter is clearly and interestingly written. The general practitioner as well as the specialist will find

the book highly readable, informative, and valuable. A very adequate bibliography follows each chapter, permitting the specialist to delve deeper into the subject.

The morphologic and physiologic characteristics of *Histoplasma capsulatum,* written by Leo Pine, U.S. Public Health Service and Duke University, are well illustrated and have 83 references to significant literature.

The saprophytic reservoirs of histoplasmosis, a subject of interest to physicians in the Midwestern histopasmosis belt, is written by Chester W. Emmons, chief of the section on medical mycology, National Institutes of Health, one of the most active workers in elucidating the cycle of infection in this disease, while the geographic distribution of H. capsulatum in the world is covered by Libero Ajello of the Communicable Disease Center, Chamblee, Ga.

The histoplasmin skin test — technique, use, and significance — are well covered by Carroll E. Palmer, while the epidemiology of this infection and this disease is discussed by Michael Furcolow. Resistance of animals and man to histoplasmosis is discussed by S. B. Salvin. All of these authorities are of the U.S. Public Health Service.

John Procknow of the University of Chicago has written a chapter on the pathogenesis of histoplasmosis in animals, while the pathogenesis of histoplasmosis in humans is covered by the editor, Dr. Henry C. Sweany. The pathology of this disease, from the primary lesion covered by Jan Schwarz, the circumscribed localized lesion by Thomas F. Puckett, to the general pathology of histoplasmosis by Henry C. Sweany, is admirably discussed and well illustrated.

One hundred and fifty pages are given over to the clinical, radiographic, diagnostic, differential diagnostic, medical and surgical aspects of this fascinating disease: the x-ray aspects by Frederic N. Silverman, the clinical types of histoplasmosis by Michael L. Furcolow, the diagnosis of histoplasmosis by W. D. Sutliff, and differential diagnosis by Henry Pinkerton. Medical and surgical management of histoplasmosis is covered by J. Lewis Yates and by John W. Polk and their associates on the staff of Missouri State Sanatorium, Mt. Vernon, one of the institutions in which large numbers of cases of pulmonary histoplasmosis have come to light.

This book will be of value throughout the medical world, since the interest in this infection is spreading as it becomes more and more apparent that the disease is much more common than first believed. It will be of special interest to general practitioners and internists in the Middlewest, where infection is common and where pulmonary histoplasmosis is, if not on the increase, definitely more often recognized.

D. F. Loewen, M.D.

Electron Microscopy of the Cardiovascular System. Bruno Kisch, M.D. Translated from the original German Text by Arnold I. Kisch, M.D. $7.50. Pp. 180. Springfield, Ill., Charles C Thomas, 1960.

Bruno Kisch has summarized his electron microscopic studies of the past ten years of the ultrastructure of the heart and blood vessels heretofore available only to those investigators who have been able to read the author's original German, French, and Italian scientific articles. This English text is translated and revised from *Der ultramikroskopische Bau von Herz und Kapillaren,* which appeared in 1957, and is supplemented by the author's most recent observations. Despite previous and some persisting technical difficulties, artefacts, and misinterpretation, the electron microscope is expected to contribute as much to the understanding of present day physiology and pathology as the light microscope contributed in the nineteenth century.

The electron microscope greatly enlarges and clarifies the conventionally recognized structure of cardiac muscle, its minute longitudinal fibrils and the multiple cross striations, as well as the minute features of the capillary wall, but also demonstrates such minute structures as the sarcosomes, mural slits in the wall of protocapillaries, the structural identity of the Purkinje fiber and the terminations of cardiac nerves which are invisible by light microscopy alone. The author believes that sarcosomes contain important enzymes responsible for muscle contraction and that the sarcosomes within muscle fibers are responsible for the heart's ability to perform heavy work without rest for a lifetime. There is a mathematical relationship between the number and type of sarcosomes and the capacity to perform heavy work not only within the same animal but also in the same muscle of all the species within the animal kingdom thus far

studied. Associated with the chronic heart failure of man, there is a progressive osmeophilic degeneration of sarcosomes which the author believes causes impaired function and leads to deposition of lipofuscin and other lipids in the muscle fibers of such hearts. Ultra microscopic droplets found in capillary wall muscle fibers and cardiac nerves represent the material for exchange in living cells and may represent a nonmolecular transfer of the materials of life in cells.

The author's ponderous Germanic style should not be allowed to deter the reader from gleaning an adequate foundation for the anticipated further developments in electron microscopy which otherwise might be unintelligible for the cardiologist.

William H. Wehrmacher, M.D.

Correspondence

Dear Dr. Van Dellen:

Thank you for the opportunity to review two newly published books for the Illinois Medical Journal. Brief reviews in accordance with the pattern in the journal are enclosed.

These reviews are not favorable ones. I am sorry for this because I cannot honestly give a good opinion of either book. It is realized that the mere writing of a book implies a greater continuity of effort than most persons are capable of. Also, every book deserves some respect in spite of its imperfections. But these two books are an affront. Max Thorek writes that viscera are to be "dusted with sulfanamide powder" in cases of evisceration. Certainly this is pernicious advice. He says that "diathermy is often a useful means of . . . keeping the functions of the vital organs, especially the liver, at their best." No authoritative surgeon could agree. Thorek ignores science and rambles verbosely. How the book achieved any of the glorious reviews printed upon its dust cover is beyond me.

The other volume has good editing as its single virtue. As a pocket sized book entitled *Surgery for the Common Man* it might have some justification, but as an encyclopedia of modern surgery it is impossible. I note that no medical book publisher would print it.

Book reviews are a serious charge. Too many ignore the reader and purchaser of the book in order to favor the writer and publisher. These reviews are submitted to you in candor and honesty. They were an interesting bit of work and were enjoyable to me.

Please call upon me again if I can be of service to you.

Sincerely,
(Signed) John J. Bergan, M.D.

Dear Dr. Van Dellen:

I would greatly appreciate your publishing the following comment. In his review in your September issue of my book, *Electrocardiography: Principles and Practices*. Dr. Wehrmacher unintentionally made two rather important errors as to fact. First, he says that I produce "no pathological observations for such empirical interpretations." But all I had said was that current theoretical interpretations are unsound, and in support of this I did produce pathological observations, as to "position" and "hypertrophy" in Chapter 5, and as to localization of myocardial infarction in great detail in Chapter 12. Inasmuch as I had not offered any empirical interpretation, I should not have been expected to produce any evidence for it. All I had said was that *if* there is to be sound interpretation it will have to be empirically established. Dr. Wehrmacher's second error is in saying that "a fifth of the book is in the form of an appendix devoted to geometric and trigonometric analyses of electropotential conduction." This is incorrect. Of the 70 pages of Appendices (19 in number), only 26 pages are so occupied, only one-thirteenth of the book; the remaining 44 pages of Appendices are devoted to entirely different things.

Sincerely yours,
(Signed) Ernest Zeisler, M.D.

If all our misfortunes were laid in one common heap, whence everyone must take an equal portion, most people would be content to take their own and depart.—*Socrates*

this hypertensive patient prefers Singoserp... and so does his physician

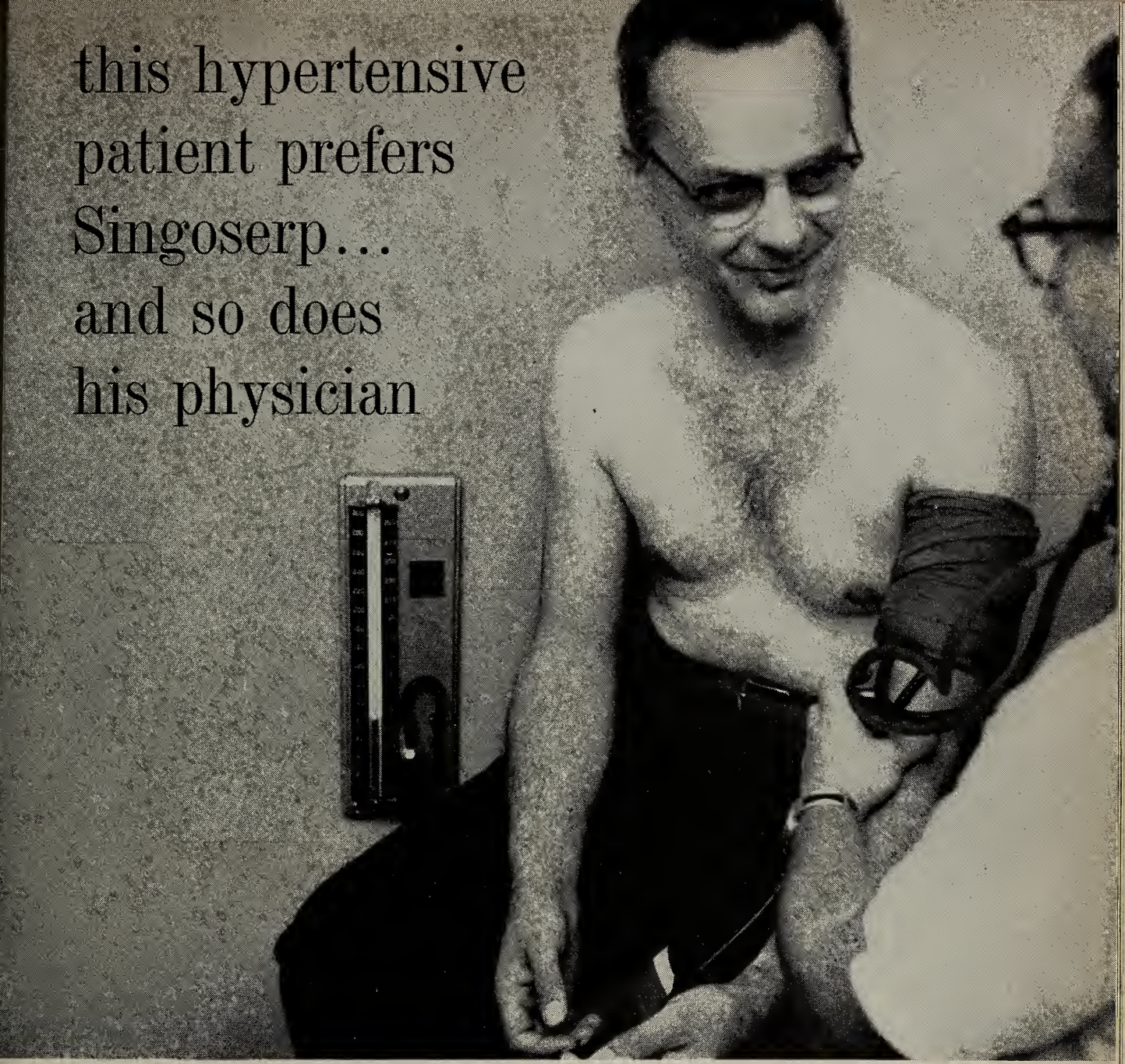


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Patient's comment: "The other drug [whole root rauwolfia] made me feel lazy. I just didn't feel in the mood to make my calls. My nose used to get stuffed up, too. This new pill [Singoserp] doesn't give me any trouble at all."

Clinician's report: J. M., a salesman, had a 16-year history of hypertension. Blood pressure at first examination was 190/100 mm. Hg. Whole root rauwolfia lowered pressure to 140/80 — but side effects were intolerable. Singoserp, 0.5 mg. daily, further reduced pressure to 130/80 and eliminated all drug symptoms.

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Meeting the cholesterol clamor

Assuming a patient has had his cholesterol reduced by diet and drugs, there is no control experiment to show that he would not have gotten along equally well without the bother and expense. It is true that some patients will be benefited psychologically and it will enable the physician to offer more frequent advice concerning the things that can be controlled.

What, then, should be the physician's attitude regarding diet, cholesterol, drugs, tobacco, and the clamor that they cause? Simply stated, his attitude should be one of moderation, a willingness to go along if a person desires treatment; he should be reserved in promising any benefit; if he prescribes drugs at all, the ones that are most promising and cheapest should be prescribed. The physician can make a plea for a normal diet, the concept of which has become confused in this generation of prosperity, "home economics," "homemaking," and high-powered advertising by the food industries.

As always, he can encourage moderation in smoking and activity and avoid the blind acceptance of highly-promoted ideas. Above all, the physician should avoid riding the loop-the-loop of the cholestrol clamor; it may end where it starts — in a low place. *Homer A. Sieber, M. D. et al. The Problem of Treatment of Atherosclerosis. Virginia M. Month. August 1960.*

Mild depression

In the past, patients with severe depression were easily recognized as needing institutional care. There has been, however, almost complete neglect of the mild and moderate degrees of depression which are so common and frequently seen in the daily practice of medicine. It has been estimated that at least five cases of unrecognized depression exist for every one diagnosed. More often than not these milder and more moderate forms of depression are labeled as neurasthenia, fatigue, chronic nervous exhaustion, nervous indigestion, and "just your nerves." *Sol Levy, M.D. Current Trend in the Treatment of Depressive Reactions. Am. Pract. & Digest Treat., September* 1960.

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(1) you remain actively engaged in a gainful occupation, regardless of age, and
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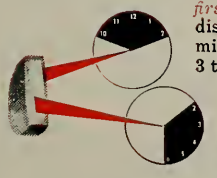
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...and for humans with STUFFED-UP SINUSES...

Your patient with sinus congestion doesn't give a hoot about anything but prompt relief. And TRIAMINIC has a pharmacologically balanced formula designed to give him just that. As soon as he swallows the tablet, the medication is transported *systemically* to *all* nasal and paranasal membranes – reaching inaccessible sinus cavities where drops and sprays can never penetrate. TRIAMINIC thereby brings more complete, more effective relief without hazards of topical therapy, such as ciliary inhibition, rebound congestion, and "nose drop addiction."

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

Relief is prompt and prolonged because of this special timed-release action:



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Phenylpropanolamine HCl ..... 50 mg.
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Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:
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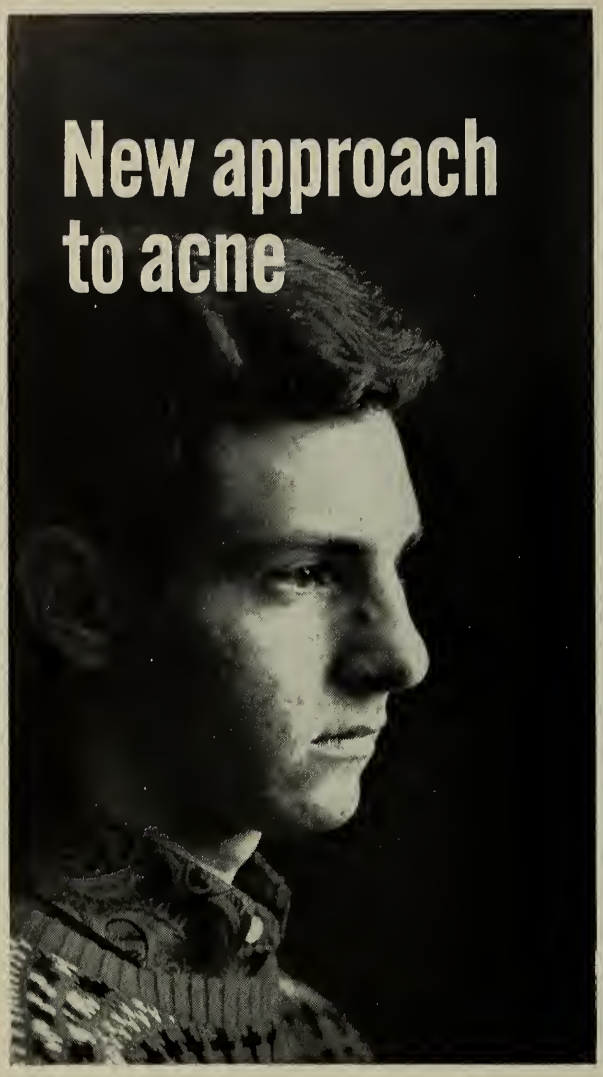
Dosage (to be administered every 3 or 4 hours):
Adults – 1 or 2 tsp.; *Children 6 to 12* – 1 tsp.;
Children 1 to 6 – ½ tsp.; *Children under 1* – ¼ tsp.

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"No patient failed to improve"[1] when pHisoHex (containing 3 per cent hexachlorophene) was added as the antibacterial wash to the standard treatment for acne. pHisoHex provides not only superior cleansing but also **continuous** antibacterial action for patients with acne. Now, with new pHisoAc keratolytic cream the management of patients with acne is simplified and even more effective. pHisoAc is applied topically once or twice daily to suppress and mask lesions and to dry, peel and degerm the skin. When used together, pHisoHex and pHisoAc are a potent complementary combination against acne.

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Malpractice in court

"Do lawyers have malpractice suits filed against them for inadequate representation, wrong advice, and ill advised law suits?"

Yes, bar associations have grievance committees and some attorneys are sued. Not only are they sued but they are disbarred. Every bar association in every state has a grievance committee. As you suggest, many of these suits are so spurious you wonder how they get by the judge to the jury trial. You wonder why the judge doesn't stop the case if it is an unjustified claim.

"Can a counter suit be filed against an attorney who accepts and prosecutes a case against a doctor for malpractice which proves to be filed with insufficient facts but has injured the reputation of the doctor involved by the ensuing publicity?"

Of course, lawyers have no greater privileges than anyone else. To intentionally harass someone, to injure his reputation whether it is a business or profession, of course, is a tort. Of course, that is actionable. The difficulty will be whether you can prove that particular allegation. The defendant will say he honestly believed he had a good case. The constitution says I don't have to take my opponent's word on the fact that I have not a good case. If my case is groundless, I have the right to have a court tell me so. I have the right to have a jury tell me so, and therefore, when I bring suit against this defendant I am exercising my constitutional rights. That is what you are confronted with. *Hon. Felix Forte in Panel on Malpractice. J. Abdominal Surg. July 1960.*



Which one wears the smallest glove?



she calls it "nervous indigestion"

diagnosis: a wrought-up patient with a functional gastro-intestinal disorder compounded by inadequate digestion. **treatment:** reassurance first, then medication to relieve the gastric symptoms, calm the emotions, and enhance the digestive process. **prescription:** new Donnazyme—providing the multiple actions of widely accepted Donnatal® and Entozyme®—two tablets t.i.d., or as necessary.

Each Donnazyme tablet contains
—In the gastric-soluble outer layer: Hyoscyamine sulfate, 0.0518 mg.; Atropine sulfate, 0.0097 mg.; Hyoscine hydrobromide, 0.0033 mg.; Phenobarbital (1/8 gr.), 8.1 mg.; and Pepsin, N. F., 150 mg. **In the enteric-coated core:** Pancreatin, N. F., 300 mg., and Bile salts, 150 mg.

ANTISPASMODIC - SEDATIVE - DIGESTANT

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Vanity and anemias in adolescents

Factors such as growth and poor nutrition in adolescent girls create an added demand for available iron. In the first place, blood volume and tissue mass increase during the adolescent growth spurt. Just after the peak of the adolescent growth spurt, with its demands for "growth iron," the first menstrual period occurs, with actual loss of iron from the body. It has been estimated that this loss is in the vicinity of 25 mg. per period. At this crucial point, the emerging woman becomes fully aware of the American obsession for trimness and slimness. Furthermore, these youngsters are unaware that girls physiologically add subcutaneous fat from 12 through 18 years. Frightened at the mere threat of plumpness, the adolescent girl immediately begins the worst sort of regimen, such as Melba toast and lemon juice, at a time when the requirements for nutrients for growth and development are still high. It is small wonder that more nutritional anemias are not detected in this age group. Such a train of events need not be confined to the economically deprived, as vanity resides in all levels of society. *F. P. Heald. Iron-deficiency Anemia in Adolescent Girls. Postgrad. Med. January 1960.*

Hospital hostess

In the smaller hospital, the hostess can play an especially valuable public relations role. Although the relationship between patient and hospital is usually closer in a small hospital than it is in a large one, there are many instances in which the small hospital's hostess program is of immense value. A friendly, sympathetic hostess does much to prevent patient misunderstanding and ill-will — before they have a chance to start.

Americus and Sumter County Hospital, a 131-bed hospital in Americus, Ga., added a hostess to its staff in November, 1959. Since that time, the hostess has eased irritations and frictions not only for patients, but also for the medical staff and hospital personnel. *Terry Hiers, Jr. A Hostess Program in a Smaller Hospital. Hospitals. Aug. 16, 1960.*

Work your way up or rust your way out.

—Holton

Fully Accredited

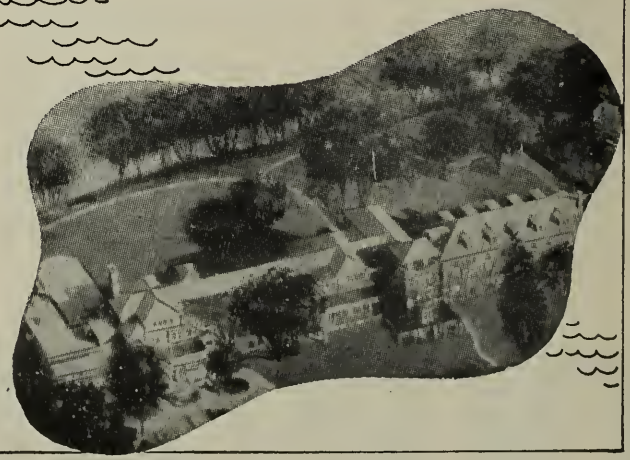
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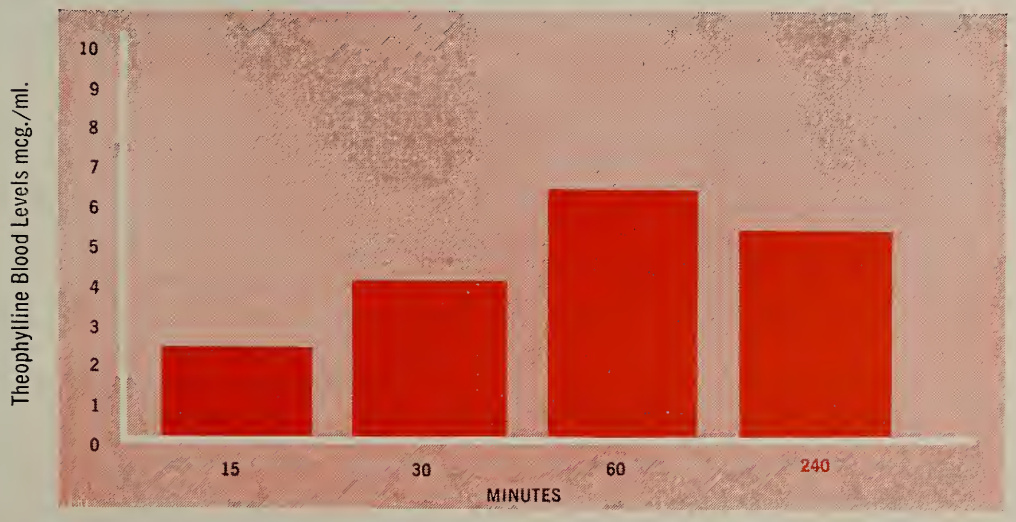
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Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) Synophylate (theophylline sodium glycinate), equiv. 0.16 Gm. (2½ gr.) Theophylline U.S.P.; 20% alcohol.
Supplied: Bottles of 1 pint and 1 gallon.

1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1960, Philadelphia, Lippincott, 1960, p. 425. 2. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Literature on request.
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"Statistically significant"

The most misunderstood of all statistical statements is that "these results are statistically significant." In the first place, statistical significance has meaning only with respect to a specific probability. In other words, a correct statement would be "these results are statistically significant with a probability of 5% (symbolically $p < 0.05$), which means that the results would occur less than five times out of 100 similar experiments if chance alone were operating. What is often overlooked is that "statistical significance" has meaning only in light of the experimental situation, and that the analysis is not complete until statements are made concerning what these results mean with regard to the process under investigation. For this reason, results which are not "statistically significant" are often very important and should be published for it is just as important to know that drug A is not effective as it is to know that drug B is effective. This concept is often overlooked by experimenters and medical journal editors who are interested only in "significant" results. *E. N. Brandt, Jr., M.S. Medical Statistics: Its Concepts and Uses. J. Oklahoma M.A. March 1960.*

Home therapy

The value of physical therapy cannot be overemphasized in any treatment program for patients with rheumatoid arthritis. Adequate treatment and careful instruction in a home program to be followed by the patient should be provided by the physiatrist, but it remains the responsibility of the supervising clinician to see that the patient faithfully follows the program. Modifications and new techniques should be introduced as needed. Too often this portion of the patient's program is neglected or omitted altogether. Hill and Holbrook estimated that not one patient in a hundred follows a proper schedule to protect his joints and maintain function. *A. J. Josselson, M.D. Rheumatoid Arthritis Current Therapy and Medical Management. California Med. May 1960.*

Our destiny changes with our thought; we shall become what we wish to become, do what we wish to do, when our habitual thought corresponds with our desire.

—*Orison Swett Marden*



"Sometimes, when I have a running nose, I'd like to clear it with TRIAMINIC®

just to check out that systemic absorption business.

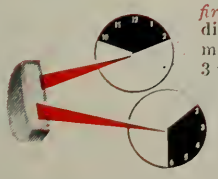
Reaches all nasal and paranasal membranes. huh?"

...and for humans with RUNNING NOSES...

You can't reach the entire nasal and paranasal mucosa by putting medication in a man's nostrils – any more than you could by trying to pour it down an elephant's trunk. TRIAMINIC, by contrast, reaches *all* respiratory membranes *systemically* to provide more effective, longer-lasting relief. And TRIAMINIC avoids topical medication hazards such as ciliary inhibition, rebound congestion, and "nose drop addiction."

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

Relief is prompt and prolonged because of this special timed-release action:



first – the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then – the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:
½ the formulation of the Triaminic Tablet.
Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:
¼ the formulation of the Triaminic Tablet.
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Adults – 1 or 2 tsp.; *Children 6 to 12* – 1 tsp.;
Children 1 to 6 – ½ tsp.; *Children under 1* – ¼ tsp.

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STOP *running noses* *and open stuffed noses orally*

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Dosage: One tablet one-half to one hour before each meal.

Lederle

Anemia in adolescents

In the past, chlorosis was regarded as the prototype of hypochromic anemia in the adolescent girl. Hypochromic anemia in the adolescent differs in several respects from the hypochromic microcytic anemia of middle age. In the adult, achlorhydria is invariably present, as is glossitis. These two findings are usually absent in the adolescent. A classic account of hypochromic anemia in the adolescent was given by Johannes Lange in 1554 ("De Morbo Virgineo"), and in the seventeenth century the efficacy of iron in its treatment was noted. Its existence was widespread and shrouded in mystery. Mention of this disease disappeared from the literature about 20 years ago. Since then, little more has been written about the hypochromic anemia of adolescence. Its disappearance from the medical scene may have been hastened by the decrease in chronic infections, by increased nutritional knowledge, and by the general availability of iron-containing foods to a large number of our population. *F. P. Heald. Iron-deficiency Anemia in Adolescent Girls. Postgrad. Med. January 1960.*

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that cuts the cost

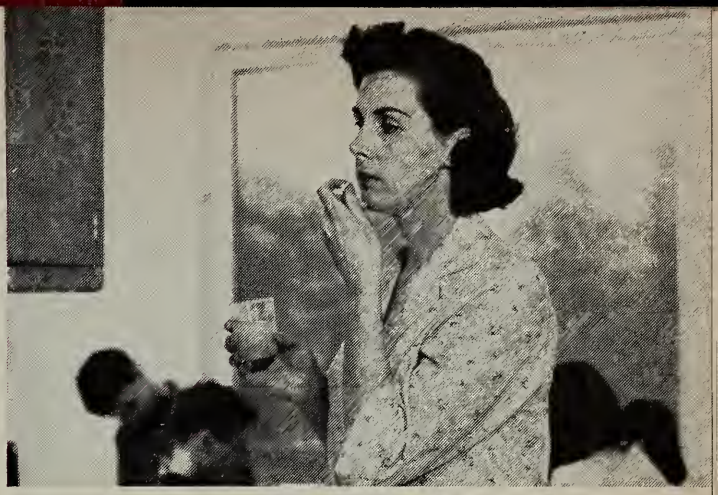
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She stays calm while on Meprospan, even under the pressure of busy, crowded supermarket shopping. And she is not likely to experience any autonomic side reactions, sleepiness or other discomfort.



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Relaxed, alert, attentive . . . she is able to listen carefully to P.T.A. proposals. For Meprospan does not affect either her mental or her physical efficiency.



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Diuretics in diabetes insipidus

Rats with severe diabetes insipidus, induced by hypothalamic lesions (Bruce and Kennedy, 1951), constantly pass urine with an osomolality of 50-100 m.osm./kg, and are therefore comparable with severe clinical diabetes insipidus. When we added chlorothiazide to their diet, they excreted abnormal amounts of sodium only for the first two days of treatment. However, their urine volume fell to less than half its original value during this period, and the osmolality doubled, and these effects persisted as long as the drug was given. The rats lost no weight; on the contrary they continued to grow quite normally, so there could not have been any serious loss of electrolytes. We had to use a very large dose to obtain the antidiuretic effect, but hydrochlorothiazide and all the other still more potent derivatives now available are antidiuretic in both rats and man in normal saluretic doses. (Kennedy and Crawford, 1959a). *G. C. Kennedy, M.B. The Chlorothiazide Diuretics and the Renal Handling of Water. Proceedings of the Royal Society of Medicine. August 1960.*



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The efficacy of **PATHIBAMATE** has been confirmed clinically in **duodenal ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety neurosis** with gastrointestinal symptoms, and **gastric hypermotility.**

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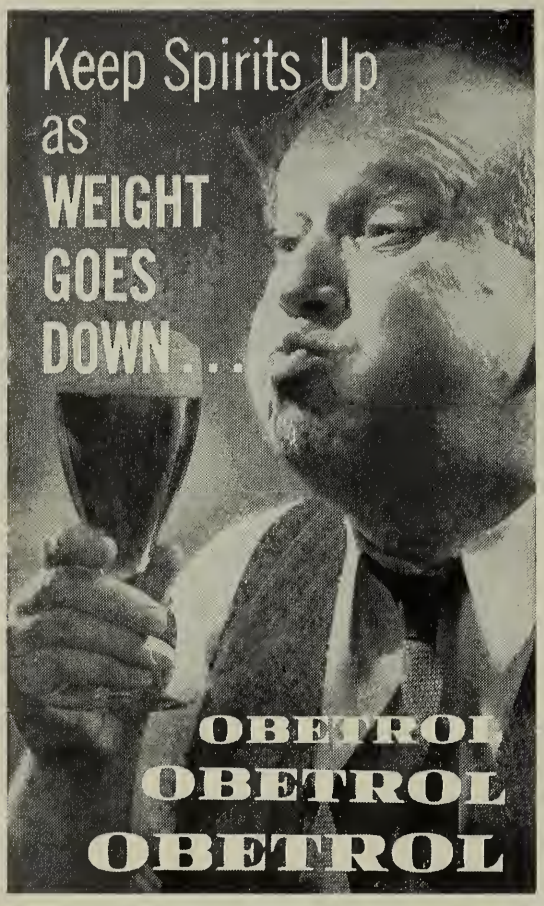
SIDE EFFECTS	TRIDIHEXETHYL IODIDE† MEPROBAMATE	TRIDIHEXETHYL IODIDE†	METHANTHELINE BROMIDE	ATROPINE SULFATE	PLACEBO
DRY MOUTH	1%	5%	72%	46%	5%
STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND MILDER	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. **Am. J. Digest. Dis.** 4:1055 (Dec.) 1959.

†PATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could distort the results of certain thyroid function tests.

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Clinical diagnoses need confirmation

As new viruses have been identified and associated with disease states, many have been found to produce signs and symptoms that formerly pointed to other agents. This characteristic is shared with other kinds of pathogens, also. In suspected tuberculosis, the culprit may turn out to be a fungus, one of many atypical acidfast bacilli, or something else quite distinct from tubercle bacilli. Wiscom dictates that a clinical diagnosis of poliomyelitis be followed by a question mark until the presence of poliovirus is confirmed in the laboratory, because the symptoms may be caused by one of the other enteroviruses. The encephalitis syndrome requires careful definition of its source. It may be produced by any of a variety of viruses, arthropodborne or otherwise; bacteria; fungi; protozoa; or chemicals. For reasons such as these, diagnostic dependence on clinical evidence alone has lost much of its validity in regard to infectious diseases. In the close partnership now necessary between the clinician and the laboratory diagnostician, the laboratory acts as arbiter when the identity of a causative agent is in doubt. *R. J. Anderson, M.D. Viruses and the Public's Health. Journal-Lancet. September 1960.*

Peptic ulcers in children

Peptic ulcer in childhood is no longer a diagnostic curiosity. In the last ten years, 95 children with an ulcer were diagnosed radiologically by our group. The apparent recent increase in incidence of childhood ulcer is undoubtedly due to two factors: an increased index of suspicion on the part of the clinician and radiologist and improved spot film equipment. Goldsberry's prediction of 50,000 undiagnosed gastric ulcers in the 1 to 6 age group suggests that this diagnosis should be suspected. *R. M. Berg, M.D. et al. Peptic Ulcers in Children. Journal-Lancet. September 1960.*

The secret of the true love of work is the hope of success in that work; not for the money reward, for the time spent, or for the skill exercised, but for the successful result in the accomplishment of the work itself.

—*Sidney A. Weltmer*

THE ORIGINAL potassium phenethicillin

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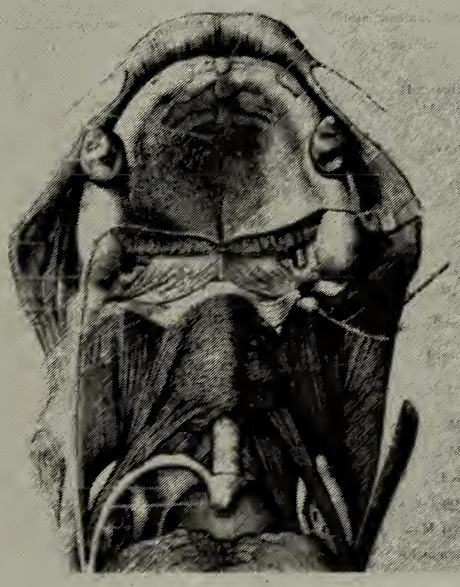
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Syncillin Tablets – 250 mg. (400,000 units)... Syncillin Tablets – 125 mg. (200,000 units)
Syncillin for Oral Solution – 60 ml. bottles – when reconstituted, 125 mg. (200,000 units) per 5 ml.
Syncillin Pediatric Drops – 1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

Complete information on indications, dosage and precautions is included in the circular accompanying each package.

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Actual case summary from the files of Bristol Laboratories' Medical Department

ACUTE TONSILLITIS

SYNCILLIN®
250 mg. q.i.d. – 5 days

B.G. 9-year-old, white male. First seen Aug. 11, 1959 with acute tonsillitis. Illness of 3 days' duration. Beta hemolytic streptococcus extremely sensitive to SYNCILLIN cultured from the throat. Patient started on SYNCILLIN – 250 mg. q.i.d. After 5 days, the infection appeared cured and the antibiotic was discontinued. No subjective or objective evidence of side reactions.

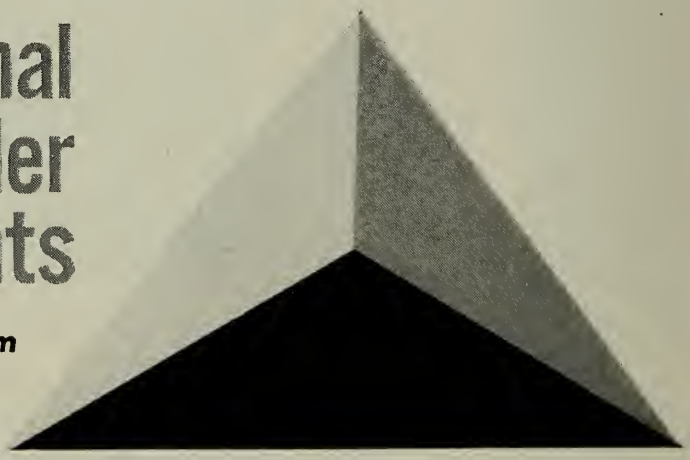
Eye worms

A large proportion of the larva found in the human eye by Wilder, have been definitely identified as *Toxocara canis*. The granulomatous lesions which result are generally mistaken for malignancy and the eye is removed. There is no knowledge of the actual frequency of cases in which the larva are fortuitously localized in the eye. It would seem to be relatively rare. However, a sufficient number of cases have been described to make nematode endophthalmitis due to *Toxocara canis* an important consideration in the differential diagnosis of malignant tumor occurring in the eye of young children. A study of the reported cases suggests that the eye is usually involved following a mild infection in which the eosinophilia and constitutional symptoms have not been outstanding. The granulomatous retinitis, together with regions of retinal detachment, may be clinically suggestive of retinoblastoma. Since the diagnosis of nematode endophthalmitis is made in retrospect after the eye has been enucleated, the clinical course of the untreated disease is not known. Considering the basic reaction caused by the larvae, there is no reason to assume that enucleation of the eye would be indicated. It is therefore suggested that all children who have a retinal lesion so suggestive of retinoblastoma that enucleation of the eye is desirable, have a hemagglutination test for *Toxocara* done also. This applies, of course, to that age group in which the possibility of infection with the larva of *Toxocara* cannot be ruled out. Also, this would permit evaluation of the test in cases where nematodes rather than cancer are found, when the eye is subsequently sectioned. *J. H. Dent, M.D. Visceral Larva Migrans. South M. J. May* 1960.

Thoracic trauma

A fractured rib is the most common chest wall injury. Although this injury may be uncomplicated, one must not disregard the fact that frequently the most serious and urgent emergencies arise from the sequelae of rib fractures. *Charles L. Roper, M.D. The Early Management of Thoracic Trauma. J. Arkansas M. Soc. August 1960.*

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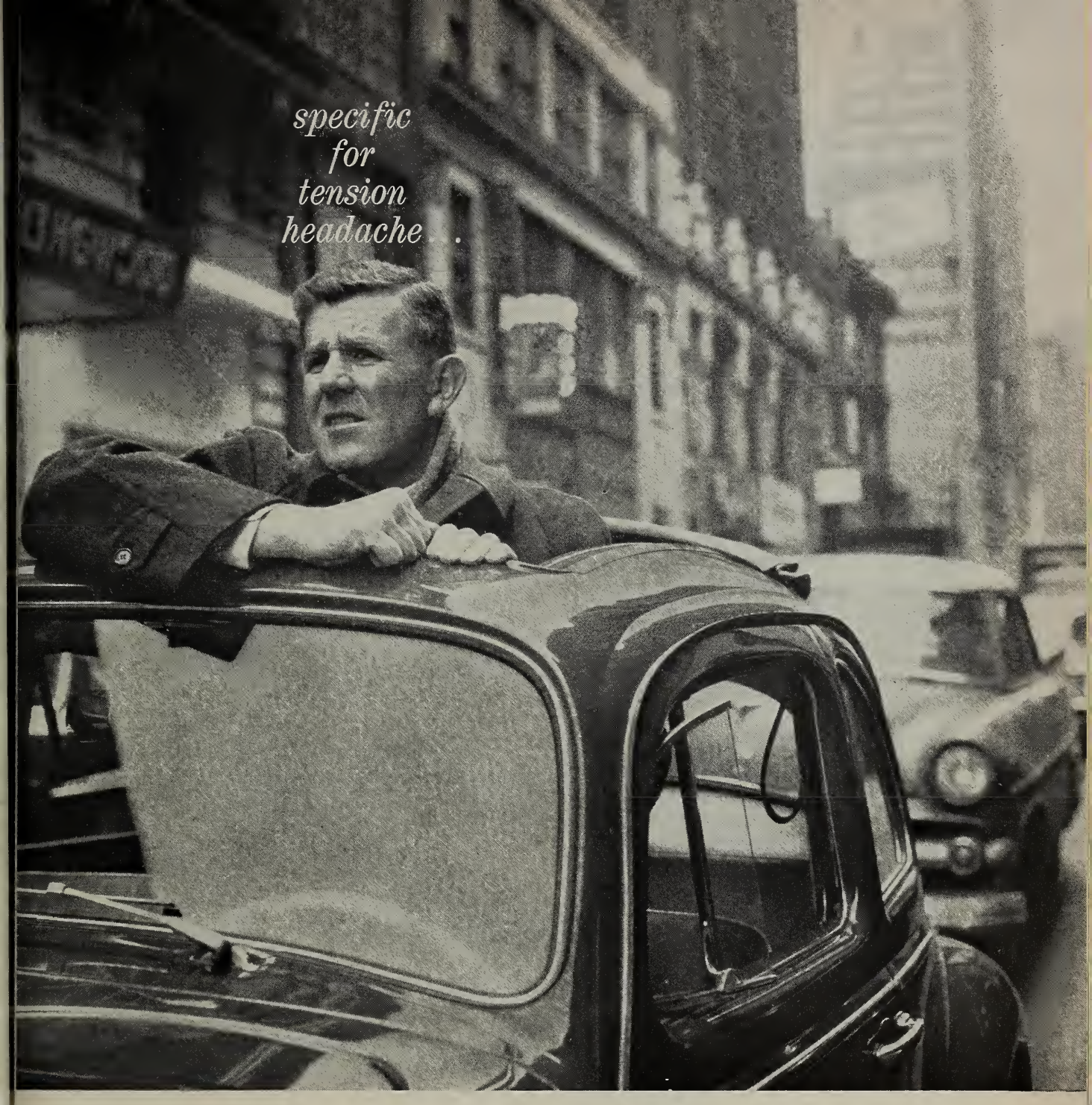
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relieves pain,
muscle spasm,
nervous tension

rapid action • non-narcotic • economical

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Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

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Each contains: Sandoptal (Allylbarbituric Acid N.F. X) 50 mg. (3/4 gr.), caffeine 40 mg. (2/3 gr.), acetylsalicylic acid 200 mg. (3 gr.), acetophenetidin 130 mg. (2 gr.).

Dosage: 1 or 2 every four hours, according to need, up to 6 per day.

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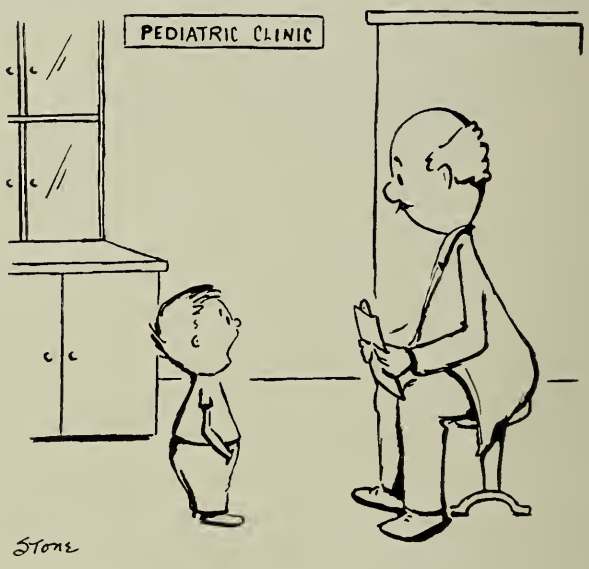
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- d-amphetamine depresses appetite and elevates mood
- meprobamate eases tensions of dieting (yet without overstimulation, insomnia or barbiturate hangover).

Dosage: One tablet one-half to one hour before each meal.

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A lap is so you don't get crumbs on the floor



Rugs are so dogs have napkins



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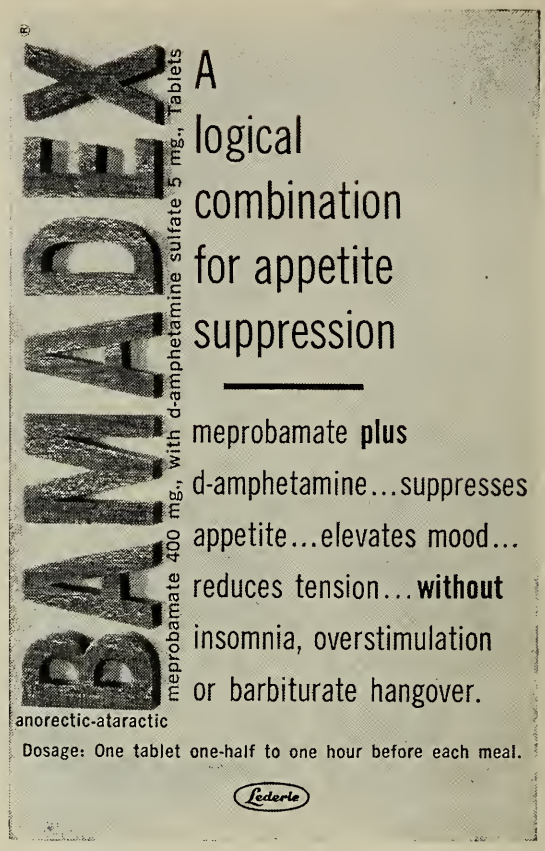
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The foundations of the world will be shaky until the moral props are restored.

—Anne O'Hare McCormick



"Cyto" and "serum" antibodies

It is generally supposed that the behavior of skin homografts indicates the behavior of other soft tissue homografts, such as endocrine gland and kidney. The cells in cartilage and the interstitial portion of cornea, however, are protected by an avascular matrix against hostile host cells. Host antibodies, undoubtedly, penetrate this matrix, but host cells do not gain entrance unless the matrix has been absorbed. If a homogenous corneal or cartilage graft becomes vascularized, host lymphocytes or other cells destroy the exposed cartilage and corneal cells as their protective matrix is removed. Thus, the term "cyto" antibody is used to designate an antibody contained in the host cell, in contradistinction to the "serum" antibody, which is in the serum outside the cell. *Lyndon A. Peer, M.D. et al. Plastic and Reconstructive Surgery. J. Internat. Coll. Surgeons. September 1960.*

Whatever strengthens and purifies the affections, enlarges the imagination, and adds spirit to sense, is useful.

—Shelley

Abstract of Council Actions

Meeting of December 11, 1960

AGREE TO JOIN WITH CHICAGO MEDICAL SOCIETY IN HEADQUARTERS

Dr. Joseph T. O'Neill, Chairman of the Permanent Home Committee, reported that in accordance with a resolution of the House of Delegates, his committee has looked into the question of occupying a home with the Chicago Medical Society. Dr. O'Neill said the CMS has an opportunity to acquire a 42,000 sq. ft. building in the Chicago Medical Center and will remodel the building in every respect. The CMS will own and finance the project and proposes that the ISMS rent space in the building at a considerable less cost per square foot than we are now paying. The building would be available in about four years. Other medical organizations also would be approached.

Since certain legislative steps are necessary in connection with the purchase, it was imperative that the attitude of the ISMS be made known at this time. The Council felt that more space would be needed at the expiration of the present lease in 1964 and that since the terms offered a substantial saving, it was voted to take at least 6,000 sq. ft. of space.

NEW FORAND TYPE BILL EXPECTED IN NEXT CONGRESS

Walter L. Oblinger, director of legislative activities, reported that a bill providing medical care of the aged under social security, along the line of the Forand Bill, probably will be presented early in the next session of Congress. Reports indicate this will be called the Douglas Bill.

BANK CONSIDERS LOANS FOR NEW PHYSICIANS

The Executive Committee has approved in principle a loan plan of the Continental Illinois National Bank to be made available to physicians entering practice. Members of the ISMS would be eligible for loans up to $5,000, with no repayment for six months. The bank is expected to announce the program shortly.

PUBLIC SERVICE SUBCOMMITTEES AUTHORIZED

The Council approved a request of the Public Relations Committee that five sub-committees be authorized and be assigned to specific projects for implementation. These would be audio-visual, media relations, community relations, member relations, and group liaison subcommittees.

FURTHER RECRUITMENT PROGRAMS ARE RECOMMENDED

The Council approved a recommendation of the Public Relations Committee that county medical societies and woman's auxiliaries develop new or improve existing recruitment programs for medical and paramedical careers. Although a suggestion by the Illinois Hospital Association for a joint Health Careers Council with the ISMS was considered a laudatory proposal it was decided to defer joining such a council at this time.

EARLY SCHEDULING OF POSTGRADUATE MEETINGS URGED

Dr. Louis R. Limarzi, Chairman of the Committee on Postgraduate Medical Education and Scientific Service, reported that postgraduate conferences have been asked for by Coles-Cumberland counties (8th district) and Williamson County (9th district), and that two other districts have expressed interest. Dr. Limarzi urged that requests for conferences be made immediately. He pointed out that these should not conflict with the Chicago Medical Society Clinical Conference in March or the ISMS annual meeting in May.

COUNCIL ISSUES WARNING ON WEIGHT CONTROL FORMULAS

The Council accepted a recommendation from the Committee on Nurition that the 900 calorie weight control milk formulas be accepted as food products provided they are used with caution and judgment.

The committee pointed out that: (1) the diets are dangerous for long term use, (2) they are not substitutes for a well balanced diet, (3) additional vitamin intake can produce undesirable results, (4) "crash" reducing programs should be avoided, (5) people developing constipation, diarrhea or other untoward symptoms should seek medical advice immediately, and (6) effective weight control requires continued adherence to a properly balanced diet.

BUDGET FOR 1961 APPROVED

The Council approved a budget for 1961. Information on this, together with a report on the dues increase to go into effect January 1, will be sent to the membership in the near future.

MORE COUNCILOR DISTRICT MEETINGS SCHEDULED

Robert L. Richards, executive administrator, reported that the reorganization program has been explained at seven councilor district meetings. Others scheduled are: 5th district, Springfield, tentatively March 9; 7th district, Effingham, tentatively February 12. A 9th district meeting is expected to be held in March. The 3rd district (Cook County) is tentatively set for February 1.

ADOPT STATEMENT OF POLICY ON HEALTH CARE OF AGED

The Council adopted a 12-point statement of policies and programs covering health care of the aged. This program will be explained in detail in a later issue of the Journal.

EMERITUS AND RETIRED MEMBERS ELECTED

Council approved emeritus status for Drs. G. H. Dietz, W. A. Hoffman, J. L. Knapp, and Stanley J. Mintek, Chicago; Harry J. Dooley, Oak Park; Johnston C. Jackman, Ft. Myers Beach, Fla. (Sangamon); James Patejdl, Palos Park; John B. Moore, Benton.

The following were elected retired members: Drs. Julia C. Aron, Wilbur R. Landon and Nina S. Litvin, Chicago; Joseph Neu, New York (CMS); Thomas F. Shortell, Phoenix (CMS); Karl I. Stevens, Park Ridge; Carl E. Schultz, Hinsdale; Henry H. Hurd, East St. Louis.

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Vol. 118, No. 6 **December, 1960**

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The Month in Washington



Election of Sen. John F. Kennedy as President made it probable that the issue of providing health care for the aged under Social Security again will be raised in Congress next year.

Kennedy will go into the White House pledged "to the immediate enactment of a program of medical care for the aged through Social Security." His intentions present a serious challenge to the nation's physicians who have vigorously opposed use of the Social Security system to provide health care for the aged.

Kennedy's program would provide what he described as "a life policy of paid-up medical insurance" for older persons. "It would provide them hospital benefits, nursing home benefits and x-rays and laboratory tests on an outpatient basis," he said in his campaign.

He said the Kerr-Mills legislation enacted into law last summer is inadequate. The medical profession supports this federal-state program to provide health care for needy and near-needy aged persons. In approving the Kerr-Mills program, Congress rejected the Social Security approach espoused by Kennedy and union labor leaders.

Kennedy's medical program also included: federal grants for construction, expansion, and modernization of medical, dental, and public health schools; federal loans and scholarships for medical students; federal grants for renovating older hospitals; increased federal financial support for medical research, including basic research, and expansion of federal programs for rehabilitation of handicapped or disabled persons.

The Federal Children's Bureau reported that the infant death rate in the United States has declined since 1958 but still shows the effect of a 1957-58 setback.

There was a steady decline in U.S. infant deaths during the 1950's but increases in 1957 and 1958. Since then, the infant death rate has headed downward again but still hasn't made up the lost ground, even though the provisional rates for 1959 (26.4 deaths under one year per 1,000 live births) and the first half of 1960 (25.9 per 1,000) showed improvements.

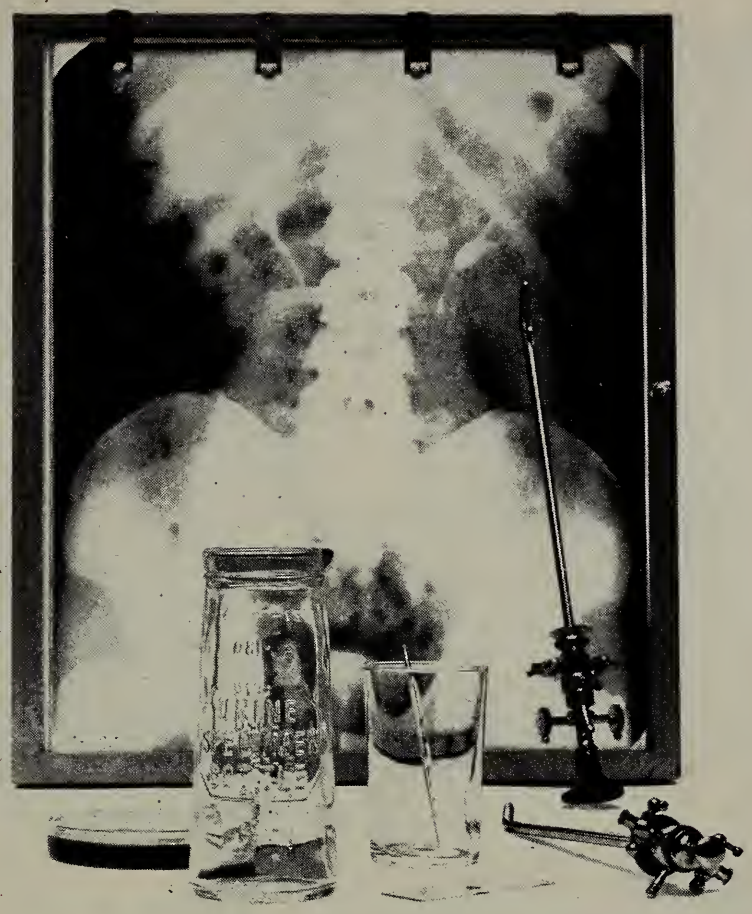
In 1915, when data were first gathered on infant mortality in this country, the rate was 99.9 per 1,000. By 1940 this had been cut to 47, and by 1950, it had been reduced to 29.2.

An all-time low of 26 was registered in 1956. It edged up to 26.3 in 1957 and 27.1 in 1958.

According to the 1959 United Nations Demographic Yearbook, nine other countries reported lower infant mortality rates than the United States in 1958. They were: Sweden 15.8, Netherlands 17.2, Australia 20.5, Norway 20.5, Switzerland 22.2, United Kingdom 23.3, Denmark 23.4, New Zealand 23.4, and Finland 24.5.

Russia reported a rate of 81 in 1950 and 40.6 in 1957, latest year for which data were reported.

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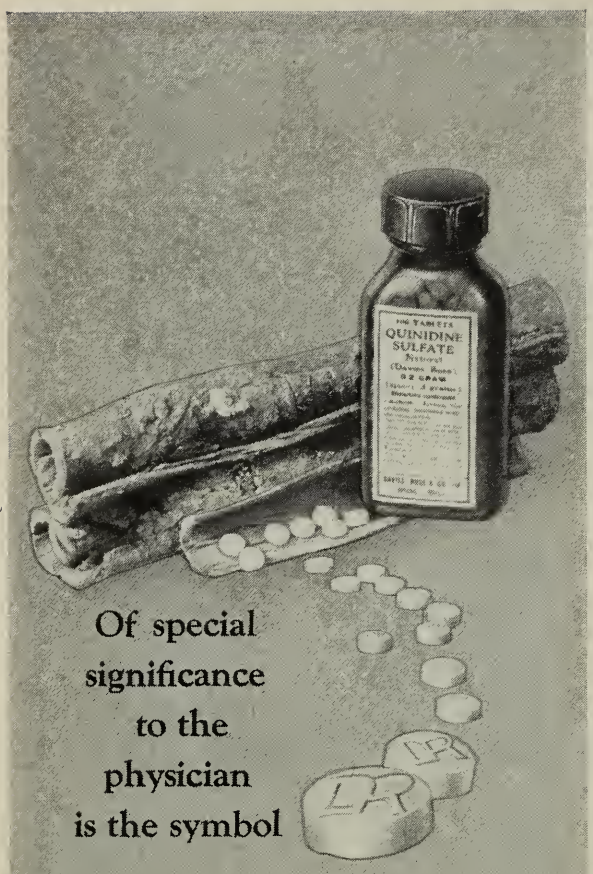
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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: *Antibiotic Med. & Clin. Ther.* 3:378 (Nov.) 1956. 2. Boger, W. P.: In: *Antibiotics Annual* 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: *Antibiotic Med. & Clin. Ther.* 5:604 (Oct.) 1958. 4. Anderson, P. C., and Wissinger, H. A.: *U. S. Armed Forces M. J.* 10:1051 (Sept.) 1959.

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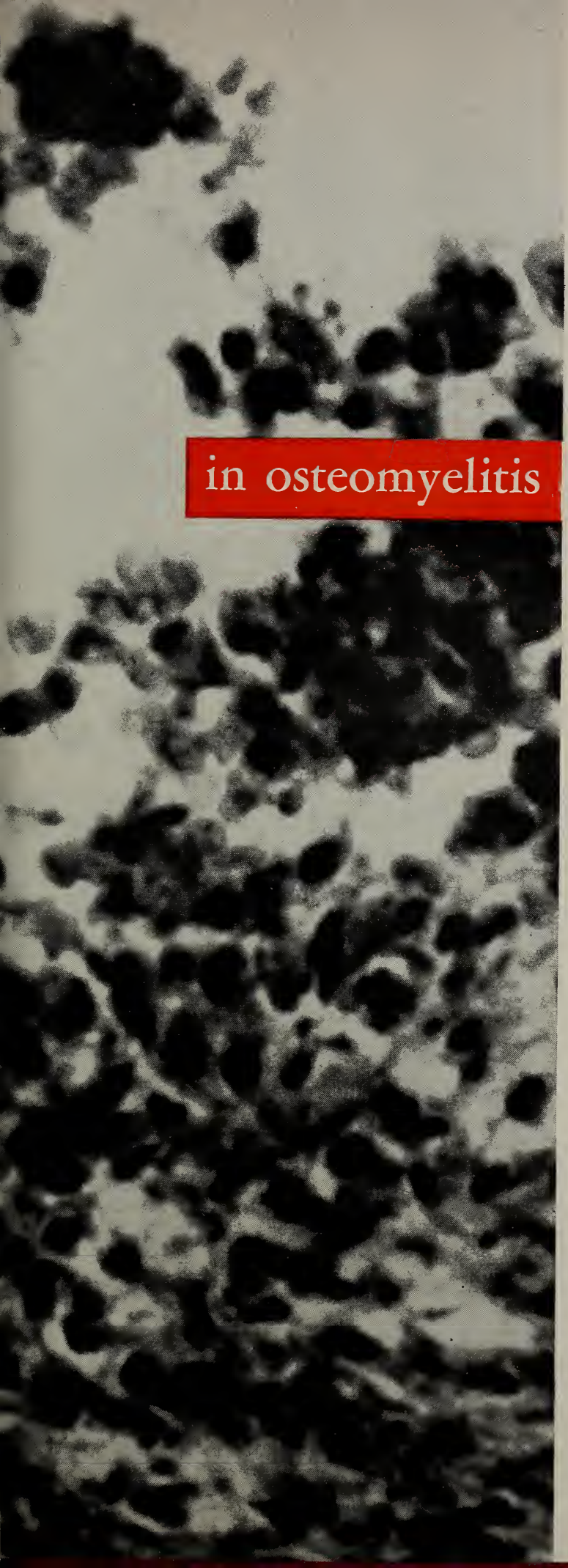
Q-7

Physiotherapy in parkinsonism

The physiotherapist is well trained in his art, but he is not a doctor and is not likely to perform the required job unless directed to do so. The doctor must specify the type, duration, and frequency of treatment as well as the parts and motor deficits needing special attention. If a patient has difficulty in putting on his coat, the physiotherapist can correct this, if ordered to do so. Similarly, he can correct difficulties in getting in and out of bed, disturbances in gait, lost finger skills, and so on, but only if the patient reaches him before the muscle contractures become irreversible. A patient with a fixed kyphosis of the upper spine will not allow the therapist to straighten his back because of the severe pain involved. Yet, some doctors fail to order physiotherapy until the patient shows advanced signs of disability or the family becomes alarmed by the progression of symptoms. This should not be. Early treatment and prevention of later complications prove less costly in the long run and are of far greater benefit to the patient than are neglect and last-minute desperate efforts at correction after the damage is done and the contractures can no longer be reversed. *Lewis J. Doshay and Louis Boshes. Three Essentials in Therapy of Parkinson's Disease. Postgrad. Med. May 1960.*

Part-time physician referrals

The part-time industrial physician has a particularly delicate problem in connection with the treatment of personal illnesses. He must be continuously vigilant in order to avoid using his industrial relationship to build up a private practice. The principle of free choice of physician must always be kept in mind. Except where there is a valid personal physician relationship with an industrial worker, referrals should be to the office of the worker's private physician and not to the office of the part-time industrial physician. Obviously, in some situations this may be difficult, especially in very small communities where the part-time industrial physician is one of a small number of physicians residing in the locality. *Mac Roy Gasque, M.D. and Carl S. Plumb, M.D. Economic Influences of an Industrial Medical Program On a County Medical Society. North Carolina M. J. September 1960.*



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Names that make sense

When I was a student, blood beneath the dura mater was not called subdural haematoma but pachymeningitis interna haemorrhagica. This convinced everyone that it was caused by inflammation and held up the discovery that head injuries caused subdural bleeding which can be surgically treated. Take another example. We all see middle-aged women with restless, painful arms, worse at night and worse after doing the washing. It is a common condition and nobody really knows what causes it. Yet according to the wide varieties of cause which are suspected—so is it given as many names: Brachial neuritis, the costoclavicular syndrome, the scalenus-anticus syndrome, cervical rib, the carpal-tunnel syndrome. This is impossibly silly. If this condition had some reasonable name like 'nocturnal brachialgia' then we could profitably discuss whether it was caused by a neuritis or by costoclavicular compression or by compression of the median nerve in the carpal-tunnel. But to name it the costoclavicular syndrome and then to discuss whether the costoclavicular syndrome is caused by carpal-tunnel compression makes no

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sense, anatomically or physically. However sure of a cause clinicians may be, a diagnostic label must be descriptive and not casual. *Richard Asher, M.D. Making Sense. J. Oklahoma M. A. August 1960.*

Psychopharmacology

Regardless of the class of drugs [tranquilizers] being used, the huge number of state hospital patients now being treated with them universally demonstrate a nondescript type of intoxication made up of the peculiar mixture of depleted sensation, narrowed attention and impaired judgment which is common to all central nervous system toxins. The safest of the drugs show a sedative action comparable to that of a glass of warm milk, and those with a more pronounced effect show few, if any, advantages over the old familiar sedatives. In no case can it be demonstrated that any effect on the patient's emotional state is produced other than that which results from the blurring of consciousness. *C. E. Goshen, M.D. Psychopharmacology Reappraised, GP. June 1960.*

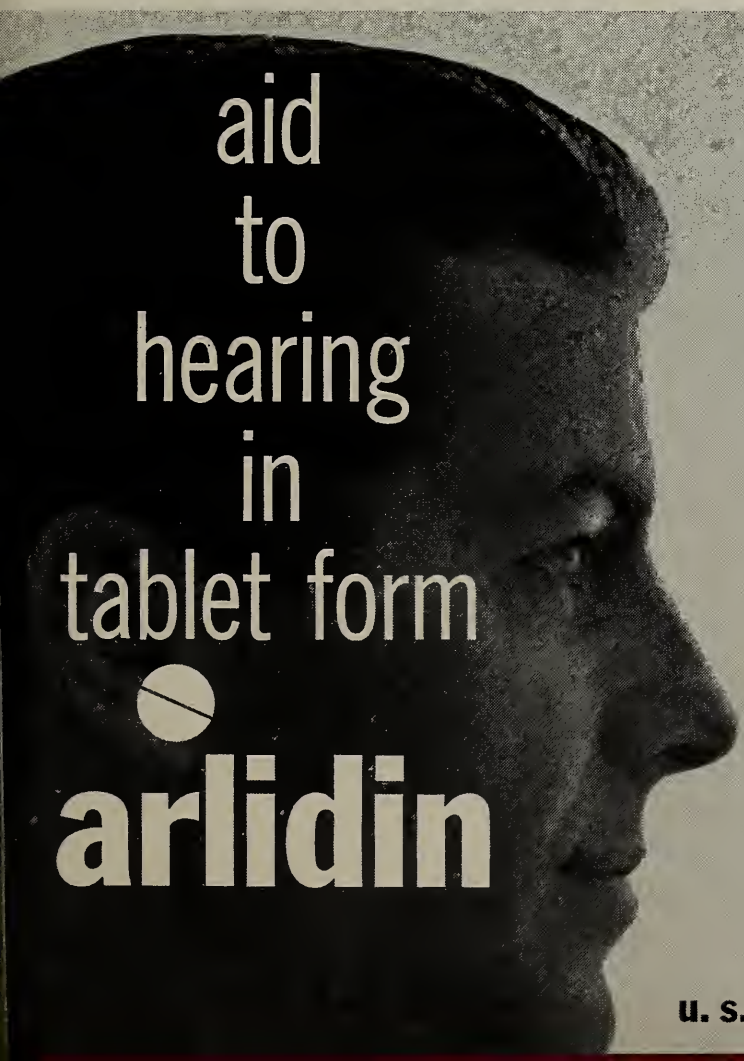
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1. Rubin. W., and Anderson, J. R.: Angiology 9:256, 1958.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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Postprandial Hyperglycemia In the Diagnosis of Diabetes Mellitus

Noah B. Levin, M.D., and Kate H. Kohn, M.D., *Chicago*

The diagnosis of mild asymptomatic diabetes mellitus is of more than academic interest. Experience has conditioned us to look for diabetes as an etiologic factor in patients with otherwise unexplained vascular disease. This search has been rewarded at times by the discovery of disturbances in carbohydrate utilization which could be found only by challenge tolerance studies. We, as well as others, have been impressed with how severe the vascular disturbances may be though the diabetes is so mild as to defy detection except by such search.

With the implied intention of discovering previously unrecognized cases of diabetes mellitus, it has been almost routine in the hospitals with which we are associated, as well as others in this area, to determine fasting blood sugar levels on almost all patients admitted. While elevation of the fasting blood sugar would certainly prompt further investigation, a normal level tends to be accepted as proof of absence of the disease and induces a sense of security. In those mildly diabetic individuals whose fasting blood sugar levels are normal, this security would be false. That this is recognized is evidenced by Joslin's statement[1] that for purposes of diagnosis, especially in mild cases, blood sugar determinations one hour after a meal are preferable to those made in the fasting state.

Formal glucose tolerance tests have long been accepted as proof of the diagnosis in mild or questionable cases. Mosenthal and Barry[2] set standards for normal and abnormal response in tolerance studies which are now generally accepted and quoted in standard texts. According to these standards, 150 mg. per 100 cc. is the peak normal value for glucose in venous blood after ingestion of 100 grams of glucose when

From the department of medicine of the Mt. Sinai Hospital and the Chicago Medical School (Dr. Levin) and the Rest Haven Rehabilitation Hospital (Dr. Kohn). *The expenses of this investigation were supported in part by a grant from the American Medical Association.*

the determination utilizes a "true" blood sugar method. Attempts have been made to simplify the procedure and still obtain diagnostic results. Conn[3] established criteria as values in excess of 160 mg. of glucose at the end of one hour, and 140 mg. after one and one half hours.

Futcher and Marcus[4] studied a group of 180 patients by measuring the level of blood glucose two hours after the ingestion of 100 grams of glucose and reported that 29 (16.1%) had significant hyperglycemia by their standards. Such an unusually high percentage of patients with abnormal results has been reported by others. Horwath et al.[5] found glucose tolerance curves of a diabetic type in 40 per cent of a group of older men. They further reported marked variability in repeated glucose tolerance curves on the same individual. Wagner[6] investigated a group of 106 aged women. Only 4 had high fasting blood sugar levels, but 24 of the group (22.6%) had peak blood sugar levels he considered in excess of normal standards. Of these, only two patients with clinically significant diabetes had levels in excess of standard. Unger[7] studied the results of glucose tolerance tests following ingestion of 100 grams of glucose in a group of 152 food handlers with normal fasting blood sugar levels. Sixty (39%) of these had two-hour blood sugar determinations over the accepted normal criteria. A study of his data shows significant elevation of the one-hour blood sugar in a considerable number of those whose two-hour level was high, and unusal elevation of the one-hour levels in a few of those whose two-hour levels were normal. He concludes that the two-hour glucose tolerance test may be variable, and that modest elevations in the specimen over the usually accepted standards are not necessarily diagnostic of diabetes. Early in the use of glucose tolerance curves Myers and McKean[8] suggested that the glucose tolerance test is not to be considered absolutely reliable, and that errors are present in both directions, with abnormally high results in normal people as well as normal curves in undoubted diabetics. Murphy[9], on the other hand, studied a group of 126 patients whose urines had been positive for reducing substances. The one-hour blood sugar level after ingestion of 100 grams of glucose was significantly high in 75 (59.5%), and her data indicate she interpreted this as diagnostic of diabetes.

It is interesting that much of the above data is at variance with the results in the Oxford study of Wilkerson and Krall[10]. Of 3,516 subjects from whom blood was drawn one hour after a meal, only 43 were found with hyperglycemia and no glycosuria. These 43 plus 25 who had both hyperglycemia and glycosuria total only 68 (1.9%) with 1-hour post-prandial hyperglycemia, a much lower percentage than found in the previously cited studies.

Method of Study

We were interested in determining whether the peak postprandial blood sugar level would be more valuable than the fasting level as a screening procedure for diabetes in patients admitted to a hospital. For this purpose 241 patients admitted to the wards of the Mt. Sinai Hospital and the Rest Haven Rehabilitation Hospital were studied. Known diabetics and seriously ill patients were eliminated; none had been on limited diets. Fasting blood samples were drawn and the patients were served a breakfast that usually included fruit, cereal, bread, egg and milk; a sample of venous blood was drawn one hour later. Glucose in blood was determined in the laboratories of the Mount Sinai Hospital by the Somogyi-Nelson method.

Results

The fasting blood sugar was significantly elevated in five patients, and they were eliminated. (Four of these were subsequently discovered to have known they had diabetes, and the fifth was ultimately considered a newly discovered diabetic.) Of the remaining 236 whose fasting blood sugar was less than 110 mg. per 100 cc., 54 had one-hour postprandial blood sugar levels between 150 and 200; 18 had over 200 mg. A total of 72 patients (30.5%) showed abnormally high levels.

Discussion

This was a special group in some respects. A large proportion were in the older age group in whom there is some indication that glucose tolerance may decrease. The percentage of Jews, who are expected to have a higher incidence of diabetes, was markedly higher than the general population. Nevertheless, making allowance for these exceptions, this would still suggest a fantastically high percentage of potential or actual

diabetics. We are unable to accept such an interpretation.

We believe these results confirm the impression that the peak height of the blood sugar level one hour after a meal is an unreliable indicator of diabetes, and that to depend on this is unwise. It would further seem that the number of patients who will have elevated blood sugar levels at this time is so great that the procedure loses value even as a screening test. Continued investigation for the purpose of setting up revised and reliable norms is indicated.

REFERENCES

1. Joslin, E. P., Root, H. F., White, P., and Marble, A. The Treatment of Diabetes Mellitus. Philadelphia, Lee and Febiger, 1952.
2. Mosenthal, H., and Barry, E.: Criteria for and Interpretation of Normal Glucose Tolerance Tests, Ann. Int. Med. 33:1175, 1950.
3. Conn, J. W.: The Prediabetic State in Man, Diabetes, 7:347, 1958.
4. Futcher, P. H., and Marcus, D. M.: Hyperglycemia and Glycosuria after Ingestion of Glucose by Ambulatory Patients over 40 Years of Age, J. Chron. Dis. 3:294, 1956.
5. Horwath, S. M., Wisotsky, R., and Corwin, W.: The Oral Glucose Tolerance Curve in Old Men, J. Gerontol. 2:25, 1947.
6. Wagner, A.: The Fallibility of the Glucose Tolerance Test in the Aged, Geriatrics 10:588, 1955.
7. Unger, R. H.: The Standard Two-Hour Glucose Tolerance Test in the Diagnosis of Diabetes Mellitus in Sujects Without Fasting Hyperglycemia, Ann. Int. Med. 47:1138, 1957.
8. Myers, G. B., and McKean, R. M.: The Oral Glucose Tolerance Test, Am. J. Clin. Path. 5:299, 1935.
9. Murphy, R. The Hidden Diabetic, Connecticut M. J. 21:306, 1957.
10. Wilkerson, H. L. and Krall, K. P. Diabetes in a New England Town, J.A.M.A. 135:209, 1947.

Age no deterent

Age is by no means the determining factor of success or failure in orthodontic treatment. Through careful diagnosis and treatment, favorable and successful results may be achieved in the adult patient. Successful treatment is entirely dependent on the patient's health and cooperation, the response of the patient to mechanical and muscular therapy, the skill of the operator in making an accurate diagnosis, the planning of the treatment, and the operator's judgment about which patient to treat and the degree of success that may be anticipated. *Sanford N. Kingsly, D.M.D. The Widening Horizon in Orthodontics: Adult Orthodontics. J. Amer. Dent. July* 1960.

Pre-lemons

There is a record of medicine practiced on this continent long before the arrival of settlers. In the year 1536, on the Gaspé Peninsula, Jacques Cartier, on the recommendation of the Indians, successfully treated an epidemic of scurvy among his crew by the use of a decoction made from the "Ameda" tree (probably a sassafras or spruce). This dread disease, which was said to have claimed, up to that time, some 10,000 seamen as victims, was not actually conquered until 250 years later. In 1753, Dr. James Lind's published investigations established the cure of this condition by lemon juice. *John Russell Twiss. Medical Practice in Colonial America. Bull. N.Y. Acad. Med. August* 1960.

Hypoglycemia in Newborn Infants*

Marvin Cornblath, M.D., *Chicago*

It has been well documented that blood sugar levels of many newborn infants are below adult standards, and values of 30 to 40 mg. per cent are not uncommon in the first hours of life.[1-6] These levels tend to be even lower in premature infants[7] and in offsprings of diabetic mothers.[8-12] Despite these findings, infants rarely develop the symptoms of hypoglycemia — flushing, pallor, eyes rolling up, sweating, "wilting" spells, cyanosis, absent Moro reflex, limpness, twitching, apnea, and convulsions or coma.[10,12-15] Prognosis of symptomatic hypoglycemia varies. While most infants have no difficulties or obvious sequellae, some die;[13,15,16] others develop organic brain damage with subsequent mental retardation, cerebral palsy, epilepsy[15], or behavior problems; while still others may have recurrent episodes of hypoglycemia.[17] The latter constitute the group with spontaneously occurring idiopathic hypoglycemia seen in older infants and children.[17] Since it has been demonstrated that hypoglycemia reduces survival of newborn animals in nitrogen[18] and that in adult humans receiving insulin shock therapy, hypoglycemia produces a reduced cerebral uptake of oxygen,[19] the maintenance of normal blood sugar levels (true sugar > 30 mg. %) in infants may be essential to provide adequate substrate for cerebral metabolism.

The sugar in blood can be elevated and maintained by three methods: (1) by giving exogenous glucose, (2) by producing a release of glucose from the liver by various hormones, or (3) by inhibiting the peripheral utilization of glucose. Epinephrine[20] glucagon[21] and cortisone[22] increase breakdown of glycogen in liver resulting in a rise in blood glucose, and ACTH and cortisone act by increasing gluconeogensis, the process by which protein is converted to glucose. In addition, either epinephrine[20] or growth hormone and ACTH[23] inhibit the peripheral utilization of sugar, thus increasing the glucose available to the brain.

Symptomatic hypoglycemia

In contrast to the infrequency of overt effects of low levels of sugar in blood during the first few hours of life, hypoglycemia after 24 hours may be symptomatic. We have recently described 8 infants with symptomatic hypoglycemia occurring on the second day of life.[15] All mothers had toxemia of pregnancy with hypertension (Table 1). In addition, albuminuria was present in 4, and 2 had excessive gains in weight. In 6 there were complication of labor and delivery as well. Infant (P.E.) was delivered by cesarean section.

Although 5 infants were premature by weight, the estimated period of gestation of 7 was 36½ weeks or more. These infants had been well until about 40 hours of age, at which time they refused feedings, became apneic, cyanotic, limp, and unresponsive. All infants had gross convulsions accompanied by blood sugars ranging from 1-24 mg. % (Table 2). In 5, the first suspicion that hypoglycemia existed was a low spinal fluid sugar (0-15 mg. %). Lumbar punctures were done because damage of central nervous system was thought to be responsible for the symptoms observed. All symptoms and signs were immediately relieved by administration of glucose intravenously. To prevent recurrences, this frequently had to be given for 3 to 5 days. Three infants (D.B., G.A. and R.T.) were given ACTH, cortisone or both in addition to parenteral glucose. Five of the 8 remained well after 10 to 15 days with no demonstrable sequellae (Table 2). Two of the infants are mentally retarded, and one died at 17 days of age of Pseudomonas sepsis and toxoplasmosis. The following is a detailed course of one of the babies described (Fig. 1).

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From the Division of Pediatrics, Sarah Morris Hospital, Michael Reese Medical Center, Chicago.

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TABLE 1. SUMMARY OF 8 CASES OF SYMPTOMATIC NEONATAL HYPOGLYCEMIA ASSOCIATED WITH TOXEMIA OF PREGNANCY

Case	Sex	Race	Gestation (Weeks)	Mother's Prenatal Course	Complications of Labor and Delivery	Birth Weight (Grams)
B. M.	M	W	36½	Severe weight gain Mild hypertension	Adherent clot over one-third of placenta	2,580
D. B.	M	C	36½	Severe pre-eclampsia	Induction of labor Precipitate delivery	2,140
P. B.	M	W	37	Moderate hypertension Albuminuria	Uterine inertia with intrapartum hemorrhage Cesarean section	2,310
G. A.	F	C	38	Hypertension Albuminuria	Prolonged ruptured membranes Breech presentation	1,360
F. Z.	M	W	39	Excessive weight gain Hypertension	Precipitate delivery	2,095
R. F.	F	W	37?	"Slight" hypertension	None	1,500
R. T.	M	C	38	Hypertension Albuminuria	Prolonged second stage	3,090
B. D.	M	W	32	Hypertension Albuminuria	None	1,812

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TABLE 2. SUMMARY OF THE COURSE OF 8 INFANTS WITH SYMPTOMATIC NEONATAL HYPOGLYCEMIA WITH IMMEDIATE RESPONSE TO INTRAVENOUS GLUCOSE

Case	Condition at Birth	Age at Onset (Hrs.)	Cyanosis	Limpness	Tremor	Apnea	Convulsions	Sugar Concentration at Symptoms: CFS (mg. %)	Sugar Concentration at Symptoms: Blood (mg. %)	Outcome
B. M.	Fair	47	x	x	x		x	-	20*	Normal at age 10 months
D. B.	Good	44-52	x	x	x	x	x	15	24* 14 1	Well at age 11 months
P. B.	Fair to poor	57	x			x	x	12	6*	Well at 9 months. Development equal to that of fraternal twin
G. A.	Good	40-48				x	x	0	4	Spastic and jittery at 4 months. Convulsions with normal blood sugar
F. Z.	Fair	44	x		x	x	x	2	2	Died at 17 days of Pseudomonas sepsis and toxoplasmosis
R. F.	Good	48-72				x	x	0	18*	Well at last follow-up at 5 months
R. T.	Good	46	x		x	x	x	-	1	Severely retarded, spastic with myoclonic seizures. Institutionalized at 3 years
B. D.	Good	40	x		x		x	-	24-18*	Well at discharge 44 days old

*Total reducing substance.
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B. M., a white male, weighed 2,578 Gm. at birth, and was born 24 days prior to the estimated day of confinement. Mrs. M. was 20 years old and in good health, seriologic test for syphilis negative and Rh positive. She was hospitalized at 34 weeks gestation because of a 34 pounds weight gain, high blood pressure (138/94), edema of hands, and 1 plus albuminuria. On a low salt diet and restricted activity, she lost six pounds in one week. Two days later, labor began spontaneously. Blood pressure remained around 130/94 during labor, which was otherwise uneventful, and lasted ten hours and 24 minutes with a second stage of 50 minutes. The baby was delivered with elective low forceps over a median episiotomy from occiputanterior position under nitrous oxide and oxygen anesthesia. A fourth degree laceration was repaired. The postpartum course was uneventful, and blood pressure on discharge was normal (104/70).

Placenta weighed 380 Gr. and had an adherent clot over one-third of the maternal surface.

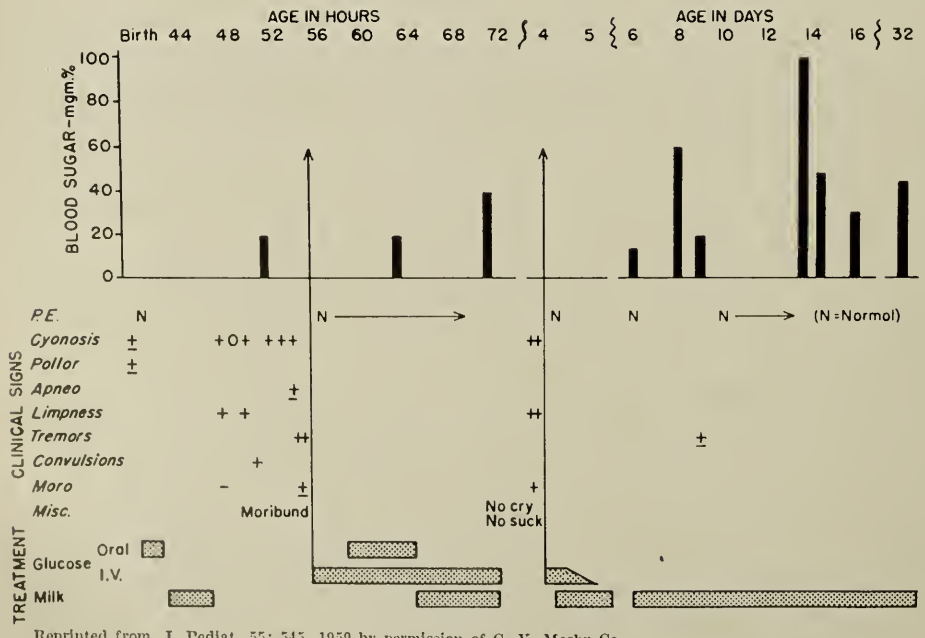
The infant breathed at birth, cried in 40 seconds, and was described as in fair condition. Slight pallor and cyanosis were noted. Physical examination at 45 minutes of age was unremarkable. At 12 hours of life routine glucose feedings were offered and taken well, as were subsequent evaporated milk feedings.

At 47 hours of age the infant was found to be limp, flaccid, cyanotic, and without a Moro reflex. While being examined, cyanosis gradually diminished. A glucose water feeding was attempted, but limpness and cyanosis increased, and there was no sucking reflex. He was noted to be jaundiced. The liver was palpable 1 cm. below the right costal margin, and the fontanel was tense. Bilateral subdural and ventricular taps were negative. During a vena puncture jerking movements of all extremities were noted, and chemistries on the specimen obtained revealed the following: sugar 20 mg.% (TRS)*, blood urea nitrogen 25 mg. %, calcium 9.3 mg. % and bilirubin 16 mg. %. Blood type was O Rh positive and the Coombs test was negative.

The infant during the next few hours improved in color and tone. At 55 hours of age, however, he again became cyanotic, jittery, and appeared moribund. Respirations were shallow, and 75 cc. of 10% glucose was given intravenously, 20 cc. rapidly, the remainder by continuous drip. Within a few minutes the baby lost all traces of cyanosis and became less jittery. A blood sugar at about 64 hours of age with 10% glucose running at 10 cc./hour was 20 mg. % (TRS).

Parenteral glucose was continued until the fourth day. Six hours later the infant again became flaccid, cyanotic, and did not cry or suck. The Moro reflex was poor. The intravenous glucose was restarted, and in 20 minutes the baby improved clinically and began to take feedings.

*Total reducing substance



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Figure 1. Clinical course in patient B.M. (Case 1).

On the fifth day the infant was permanently weaned from the glucose infusion and was maintained without symptoms on frequent small feedings of evaporated milk with 10% added carbohydrate. On the sixth day, after a nine-hour fast, the blood sugar was 14 mg. %**. There were, however, no apparent clinical signs of hypoglycemia. Normal intravenous glucose tolerance test was obtained. Thereafter the infant did well on frequent feedings, with blood sugars two to three hours after feedings of about 60 mg. % (TRS). A fasting sugar on day 9 was 20 mg. %.

On the seventh day of life the blood urea nitrogen, phosphorus, bilirubin, and total and fractional proteins were all within normal limits. The infant fed well, gained weight, and became more alert. He appeared normal at 3 weeks of age and weighed 2,750 Gr. (200 Gr. over birth weight). His blood sugars ranged from 60 to 90 mg. % (TRS) 4 hours after feedings, and he was discharged on an evaporated milk formula containing 10% added carbohydrate.

Additional studies during his hospital stay revealed negative cultures of the blood, ventricular, and spinal fluids. X-rays of skull and chest were normal. Repeated urinalyses were unremarkable with no glucosuria or acetonuria. Serum electrolytes were also normal. Subsequent fasting levels of sugar in blood at 2½, 5 and 7 months of age were 80, 92 and 74 mg. % respectively. He has grown and developed normally during this time.

Table 3. Differential Diagnosis in Neonate with: Eyes rolling up, Flushing, Pallor, Sweating, "Wilting" Spells, Twitching, Convulsions, Cyanosis, Limpness, Apnea, Absent Moro, Coma.

1. Central nervous system
   - Birth injury, subdural hematoma
   - Congenital defect
   - Infection
2. Sepsis
3. Kernicterus
4. Heart disease
   - Congenital
   - Auricular fibrillation
5. Metabolic aberration
   - Pyridoxine deficiency or dependancy
   - Uremia
   - Hypocalcemia
   - Hypoglycemia

**True sugar

Therefore, this infant presented with failure to suck, twitching, cyanosis, apnea, limpness, absent Moro reflex, and convulsions at 47 hours of age. The differential diagnosis considered in such a neonate is outlined in Table 3. Because of a bulging fontanel, subdural and intraventricular taps were done, since birth injury with a subdural hematoma, a congenital cerebral defect, or meningitis could be responsible for these symptoms. Sepsis, kernicterus (bilirubin was 16.0 mg. % at 48 hours of life), or heart disease can produce a similar clinical course.

The metabolic aberrations which have been responsible for symptoms in the neonate include pyridoxine deficiency[24] or dependency[25], uremia due to congenital anomalies of the kidneys or obstruction to urinary outflow, hypocalcemia[26] or hypoglycemia[13,15]. That the infants described had hypoglycemia is apparent from the low levels of sugar in blood and spinal fluid, and, even more important, almost immediate alleviation of symptoms with parenteral glucose and need for continued extra glucose to prevent recurrence.

Etiologic factors

Although symptomatic hypoglycemia is uncommon in the newborn period, a number of infants have been described with this condition due to a variety of etiologic factors[7,10,16,27,28]. A classification of hypoglycemia for all age groups as modified from Conn and Seltzer[29] is outlined in Table 4. Many of the organic as well as functional causes of hypoglycemia have been described in the neonate. There is a report of one patient with manifest hypoglycemia during the newborn period, in which an islet cell adenoma was discovered at autopsy[16]. Hyperplasia of islet cells has been incriminated as a cause of hypoglycemia in newborns of both diabetic and nondiabetic mothers[13]. Glycogen storage disease can be a cause of convulsions secondary to hypoglycemia as early as the third day of life[28], and galactosemia can produce symptoms shortly after birth. Adrenal hemorrhage as well as lesions of the central nervous system has been associated with shock-like symptoms and hypoglycemia in the neonate[27]. Of McQuarrie's 25 cases of idiopathic spontaneous hypoglycemia in infants and children 2 became clinically apparent on the first day of life and another during the first week[17]. Although in many instances it is possible to determine the

TABLE 4. Etiologic Classification of Spontaneous Hypoglycemia Modified from Conn and Seltzer.

I.	Organic
	A. Hyperinsulinism
	Islet cell adenoma
	Hyperplasia of islet cells
	Absence of α cells
	B. Hepatic Disease
	Fatty degeneration
	Cirrhosis — congenital or acquired viral
	Acute Hepatitis toxic
	Glycogen storage disease
	Galactosemia, congenital
II.	C. Adrenal Dysfunction
	Cortical:
	Idiopathic cortical atrophy
	Hemorrhage
	Sepsis
	Congenital adrenal hyperplasia
	Neoplasms
	Medullary: Lack of epinephrine response[36]
	D. Anterior Pituitary Hypofunction
	Pituitary dwarf
	Cretin
	E. Central Nervous System Lesions
	Cerebral hemorrhage
	Congenital malformations
	Tumors — hypothalamus or brain stem
III.	F. Functional
	Hyperinsulinism — functional
	Alimentary — infancy
	Staub-Traugott Phenomenon
	Renal glycosuria
	Galactosemia — acquired
	Idiopathic spontaneous hypoglycemia of infancy
	1. Familial
	2. Protein sensitive
	Faulty "Physiologic Regulation" in newborn
	1. Normal mother
	2. Diabetic mother
	3. Toxemic mother[35]

underlying cause of the hypoglycemia, the etiology in the group of infants of toxemic mothers is not apparent. Of interest, however, is that these infants were premature by weight and that the mothers did have pre-eclampsia.

Hypoglycemia occurring during the first days of life is greater in premature than in full term infants, especially under stress[7]. Many premature babies are unable to maintain normal levels of blood sugar, which may be another aspect of liver immaturity similar to their inability to conjugate bilirubin[30]. In addition, all of the mothers showed some manifestations of pre-eclampsia. Although it is known that infants born to mothers with toxemia of pregnancy have a higher mortality rate during the first week of life[31], the cause of this increased morbidity and mortality is for the most part unknown. In addition to having hypoglycemia, these infants are frequently edematous, feed poorly, and gain weight slowly[32]. Cyanotic attacks have also been described[33]. Follow-up studies of children of toxemic mothers[34] indicate an increased incidence of reading disability, cerebral palsy, and behavior disorders. The extent to which hypoglycemia contributes to later problems in these children requires further investigation.

Finally it is implied by some observers that, since during the neonatal period many newborn infants are unaffected, low levels of sugar in blood have no clinical significance. However, it has been demonstrated that hypoglycemia can be responsible for apnea, cyanosis, limpness, absent Moro reflex, twitching, listlessness, and convulsions, and therefore must be considered in a differential diagnosis of any infant presenting these signs in the first week of life. Furthermore, hypoglycemia may be responsible for later sequellae in the asymptomatic infant.

Summary

1. Newborn infants may have lower blood sugars than do older children and adults. The differential diagnosis in the newborn with flushing, pallor, eyes rolling up, sweating, twitching, cyanosis, and convulsions has been presented.

2. Symptomatic hypoglycemia occuring in infants of mothers with toxemia of pregnancy has been described.

3. The etiologic factors producing hypoglycemia in the neonate have been discussed.

REFERENCES

1. Hartmann, A. F., and Jaudon, J. C.: Hypoglycemia, J. Pediat. 11:1, 1937.
2. Ketteringham, R. C., and Austin, B. R.: Blood Sugar During Labor, at Delivery and Postpartum, with Observations on Newborn, Am. J. M. Sc. 195:318, 1938.
3. Norval, M. A., Kennedy, R. L. J., and Berkson, J.: Blood Sugar in Newborn Infants, J. Pediat. 34:342, 1949.
4. Farquhar, J. W.: Control of the Blood Sugar Level in the Neonatal Period, Arch. Dis. Childhood, 29:519, 1954.
5. Creery, R. D. G., and Parkinson, T. J.: Blood Glucose Changes in the Newborn. I. The Blood Glucose Pattern of Normal Infants in the First 12 Hours of Life, Arch. Dis. Childhood, 28:134, 1953.
6. Cornblath, M., et al.: Studies of Carbohydrate Metabolism in the Newborn. III. Some Factors Influencing the Capillary Blood Sugar and the Response to Glucagon during the First Hours of Life, Pediatrics (In Press).
7. Norval, M. A.: Blood Sugar Values in Premature Infants, J. Pediat. 36:177, 1950.

8. Miller, H. C., and Ross, R. A.: Relation of Hypoglycemia to the Symptoms Observed in Infants of Diabetic Mothers, J. Pediat. 16:473, 1940.
9. Reis, R. A., De Costa, E. J. and Allweiss, M. D.: The Management of the Pregnant Diabetic Woman and her Newborn Infant, Am. J. Obstet. & Gynec. 60:1023, 1950.
10. Pennoyer, M. M., and Hartmann, A. F.: Management of Infants Born of Diabetic Mothers, Postgrad. Med. 18:199, 1955.
11. Farquhar, J. W.: The Significance of Hypoglycemia in the Newborn Infant of the Diabetic Woman, Arch. Dis. Childhood 31:203, 1956.
12. Komrower, G. M.: Blood Sugar Levels in Babies Born of Diabetic Mothers, Arch. Dis. Childhood 29:28, 1954.
13. Hartmann, A. F.: Pathologic Physiology in Some Disturbances of Carbohydrate Metabolism, J. Pediat. 47:537, 1955.
14. Cornblath, M., et al.: Studies in Carbohydrate Metabolism in the Newborn. IV. The Effect of Glucagon on the Level of Sugar in Blood in Offspring of Diabetic Mothers. (To be published.)
15. Cornblath, M., Odell, G. B., and Levin E. Y.: Symptomatic Neonatal Hypoglycemia Associated with Toxemia of Pregnancy, J. Pediat. 55:545, 1959.
16. Sherman, H.: Islet-Cell Tumor of Pancreas in a Newborn Infant (Nesidioblastoma), Am. J. Dis. Child. 74:58, 1947.
17. McQuairie, I.: Idiopathic Spontaneously Occurring Hypoglycemia in Infants, A.M.A. Am. J. Dis. Child. 87:399, 1954.
18. Himwich, H. E., et. al.: Mechanisms for the Maintenance of Life in the Newborn during Anoxia, Am. J. Physiol. 135:387, 1942.
19. Himwich, H. E., et al.: Cerebral Blood Flow and Brain Metabolism during Insulin Hypoglycemia, Am. J. Physiol. 132:640, 1941.
20. Cornblath, M., Levin, E. Y., and Gordon, H. H.: Studies in Carbohydrate Metabolism of the Newborn. I. Capillary-venous Differences in Blood Sugar in Normal Newborn Infants, Pediatrics 18:167, 1956.
21. Cornblath, M., Levin, E. Y., and Marquetti, E.: Studies in Carbohydrate Metabolism in the Newborn. II. The Effect of Glucagon on the Concentration of Sugar in Capillary Blood of the Newborn Infant, Pediatrics 21:885, 1958.
22. Long, C. N. H., Katzin, B., and Fry, E. G.: The Adrenal Cortex and Carbohydrate Metabolism, Endocrinology, 26:309, 1940.
23. Park, C. R., et al.: The Effect of Growth Hormone on Glucose Uptake by the Isolated Rat Diaphragm, J. Biol. Chem., 197:151, 1952.
24. Bessey, O. A., Adam, D. J. D., and Hansen, A. E.: Intake of Vitamin B_6 and Convulsions, Pediatrics 20:33, 1957.
25. Hunt, A. D. Jr., et al.: Pyridoxine Dependancy, Report of a Case of Intractable Convulsions in an Infant Controlled by Pyridoxine, Pediatrics 13:140, 1954.
26. Craig, W. S., and Buchanan, M. F. G.: Hypocalcemic Tetany Developing within 36 Hours of Birth, Arch. Dis. Childhood 33:505, 1958.
27. Hill, E. E., and Williams, J. A.: Massive Adrenal Hemorrhage in the Newborn, Arch. Dis. Childhood 34:178, 1959.
28. Mason, H. H., and Anderson, D. H.: Glycogen Disease, Am. J. Dis. Child. 61:795, 1941.
29. Conn, J. W., and Seltzer, M. D.: Spontaneous Hypoglycemia, Am. J. Med. 19:460, 1955.
30. Lathe, G. H., and Walker, M.: An Enzymatic Defect in Human Neonatal Jaundice and in Gunn's Strain of Jaundiced Rats, Biochem. J. 67:9 (Proceedings) 1957.
31. Brown, E. W., Lyon, R. A., and Anderson, N. A.: Causes of Prematurity. VI. Influence of Toxemia on the Incidence of Prematurity, Am. J. Dis. Child. 71:378, 1946.
32. Brash, A. A.: The Effect of Toxemia of Pregnancy upon the Fetus and Newborn Child, Arch. Dis. Childhood, 24:107, 1949.
33. Illingworth, R. S.: Cyanotic Attacks in Newborn Infants, Arch. Dis. Childhood, 32:328, 1957.
34. Deaver, G. G.: Etiological Factors in Cerebral Palsy, Bull. New York Acad. Med. 28:532, 1952.
35. Broberger, O., Jungner, I., and Zetterstrom, R.: Studies in Spontaneous Hypoglycemia in Childhood. Failure to Increase the Epinephrine Secretion in Insulin-Induced Hypoglycemia, J. Pediat. 55:713, 1959.

Congestive heart failure

Until recently, seemingly separate clinical entities were explained by the hemodynamic concepts of "forward" and "backward" heart failure. Forward hear failure was considered a clinical state which resulted from a marked reduction in left ventricular output. Its principal manifestations were attributed to decreased perfusion of vital tissues manifested by low arterial pressure, fatigue, and weakness. In the case of the kidney, reduced blood flow presumably led to inadequate excretion of sodium and water with resultant fluid retention and edema formation. Backward failure referred to passive engorgement of the venous system caused by the heart's inability to accept and promptly expel all of the venous blood that was returned to it. Damming up of blood proximal to the failing left ventricle increased hydrostatic pressure in the pulmonary veins and was a major factor in the production of pulmonary edema. Decompensation of the right ventricle resulted in elevation of pressure in the right atrium and in great veins. Engorgement of veins in the subcutaneous tissues and in viscera led to augmentation of serous effusions and edema. *Max Harry Weil, M.D., and Herbert Shubin, M.D. Current Concepts on the Management of Congestive Heart Failure. Diseases of the Chest. August* 1960.

Clinical-Surgical Conferences



COOK COUNTY HOSPITAL

Laryngeal Trauma

MODERATOR: Robert J. Freeark, M.D.
Director of Surgical Education
Cook County Hospital

DISCUSSANT: Paul H. Holinger, M.D.
Professor Bronchoesophagology, University of Illinois College of Medicine; Attending Surgeon, Presbyterian-St. Luke's Hospital, Research and Education Hospital, and Children's Memorial Hospital

DR. ROBERT FREEARK: Often neglected in discussions relating to multiple injury is the problem of laryngeal trauma. Although damage to the voice box and upper trachea is infrequent, the demands upon the knowledge and skill of the responsible physician may be quite exacting. While the importance of an adequate airway to the severely injured patient is a matter of common knowledge to most doctors, other considerations such as preservation of the voice and maintenance of this airway after the initial injury are often overlooked.

Dr. Paul H. Holinger is a surgeon of international reknown in virtually all aspects of disorders of the upper air and food passages. His achievements and honors are far too numerous to recite and are undoubtedly well known to most of you. The subject of laryngeal trauma is one in which he has studied and written extensively and he brings to us years of experience in the management of this problem to which he has contributed so much. We have asked him to discuss two cases that are somewhat typical of trauma to the larynx as encountered in a large charity hospital. I hope that he will take the opportunity to stray from the penetrating injuries exemplified by these patients to the more common type of blunt injury often seen in high speed automobile accidents.

As if the presence of our distinguished guest were not enough, we are further honored by the presence of an eminent otolaryngologist from England who is visiting with Dr. Holinger and has been kind enough to accompany him to our conference today. Mr. Philip Reading is head of the Ear, Nose, and Throat Section of Guy's Hospital in London. We hope he will feel free to join in the discussion.

We will begin by presentation of the cases.

Case 1

DR. CHARLES JACKSON (Surgical Resident): This 30 year old white male entered Cook County Hospital on September 13, 1958, with a history of stab wound of the neck by unknown assailant two hours prior to admission. The patient had some difficulty with speech but stated that since the injury, he had noticed moderate respiratory distress and had coughed up a number of blood clots.

On physical examination the patient appeared to be in acute distress but vital signs were stable. There was a ¾ inch longitudinal laceration of the neck at the level of the cricoid just to the right of the midline. There was moderate bleeding from this wound, and subcutaneous emphysema was readily palpable in the soft tissues of the neck. The remainder of the physical examination was not remarkable, and the patient was taken to surgery shortly after admission.

Exploration of the laceration under local anesthesia revealed a longitudinal incision through

the cricoid cartilage and first tracheal ring such that by gently retracting the cut edges, direct visualization of the entire subglottic larynx was possible.

Dr. Freeark: Before proceeding further, I should point out that x-rays of the neck were intentionally omitted rather than risk further aggravation of his respiratory distress. Perhaps Dr. Holinger will advise us as to the proper management of this wound as it was encountered by the operating surgeon.

Dr. Paul H. Holinger: In the problem of stab wound of the neck, it is not uncommon for a wound as deep as this to avoid a great vessel. Apparently they were not involved here. If the incision in this case involves the cricoid cartilage, we have a different problem than if we had severance of the membranous trachea only. The cricoid is the only portion of the airway which is a complete cartilaginous ring; so it is an extremely important structure in the maintenance of the air passage. Did this incision actually sever the cartilage or did it merely cut the membrane between the cartilage and the first tracheal ring?

Dr. Jackson: It severed the entire cricoid cartilage and the first tracheal ring. It did not cut the membrane between the thyroid cartilage and the cricoid.

Dr. Holinger: Then the problem is more difficult because we must assure restoration of the ring of the cricoid cartilage. If respiratory distress is severe or hemorrhage into the trachea has occurred, the first thing to do is a tracheostomy, getting away from the original incision and placing the tracheostomy low in the neck at the level of the third tracheal ring. Then the cricoid cartilage may be repaired as well as possible. It may be necessary to support the repair of this cartilaginous ring injury. The logical procedure is to splint the part, but external splinting of the cricoid cartilage. is not easy. It can be splinted internally, however. The procedure involves placing a polyethylene tube inside the cartilage just beneath the vocal cords and above the tracheostomy tube and leaving this internal splint in place for several months until healing is assured. The patient must be kept under observation during this period. If accurate approximation can be obtained by merely suturing the torn cartilage, then one could get along without splinting, but in a man who was attacked as this man was and who, no doubt, lives a rather vigorous life, the chance that a second injury will result in a collapse or mal union of your repair is a distinct possibility. Should this occur, the airway becomes greatly reduced. If one chooses to use an internal splint in such a patient, it should fit comfortably in the tracheal lumen and both ends must be sealed. If the ends are open, the patient will aspirate almost everything he tries to swallow.

When one encounters a patient with a laryngeal or neck injury, if time and the condition of the patient permit, it is wise to look at the larynx with a mirror and see how much motility there is to the vocal cords. It is important to know of the possibility of paralysis of one cord in association with this trauma. Probably there was none in this case in view of the site of the laceration which I take it was far anteriorly. If it is lateral, there might be paralysis.

Another thing to do is obtain a lateral x-ray film of the neck taken for soft tissue structures. This gives a good view of the tracheal airway as shown by the radiolucent air column. Narrowing or deformity of this air column will identify the extent of collapse of structures like the cricoid cartilage, and should there be swelling and hematoma within the tracheal mucosa, one is alerted to its severity and location. External examination may prove misleading. So in any injury such as this, we may determine if the cartilage is involved, and with a mirror, whether there has been injury to the recurrent nerve. If the airway is compromised, tracheostomy should be performed. Following this, injured structures should be repaired anatomically and provision made for maintenance of this repair by inserting an internal splint.

I wonder if Mr. Reading would care to comment on this case.

Mr. Philip Reading, London England: Judging from the nature of the injury in this man, I should assume that he was stabbed from the front and I would suggest that one should do something about investigating the posterior laryngeal and tracheal wall for the possibility of esophageal injury.

Dr. Jackson: We did what Mr. Reading suggested. After anesthetizing the patient's larynx with a topical anesthetic, we looked at the posterior laryngeal wall because we thought there might be a through-and-through laceration into

the esophagus. There was no evidence of such. Then we tried to look at the cords from below. They looked normal and appeared to be moving well. We did not laryngoscope the patient. Following a thorough inspection of the larynx and adjacent structures, the cricoid and first tracheal rings were repaired using interrupted catgut sutures on an atraumatic needle. The reduction seemed stable and we did not perform a tracheostomy or insert an internal splint. After approximating strap muscles over the repair and inserting a small soft rubber drain, we closed the wound. The patient had an uneventful postoperative course and has continued to do well.

Dr. Freeark: I might add that he has continued to do well only in so far as his larynx and airway are concerned. Our inability to present him to you at this time — some three months after the initial injury — is due to the fact that he is in the hospital recovery ward. His injury this time was a stab wound of the abdomen incurred last night at the hands of an unknown assailant. No doubt he was out looking for his first attacker.

Dr. Jackson: Dr. Holinger, do you recommend tracheostomy for all laryngeal injuries or principally those in which the cricoid ring has been severed?

Dr. Holinger: The injury to the cricoid ring is an important deciding point. The degree of tracheal damage is another factor. I believe both Mr. Reading and I would sleep better with a tracheotomy tube in place after such a repair rather than be concerned that a postoperative hematoma might increase respiratory obstruction.

Dr. Freeark: Dr. Jackson has had an unusual experience for a general surgeon with three such wounds. I believe he did a tracheostomy in the first one but in the other two elected to omit it and merely repaired the injury. All came out with excellent results.

Case 2

Dr. John Boswick (surgical resident): This 50 year old white female entered Cook County Hospital in shock with self-inflicted wounds of the neck and wrists of twelve hours' duration. Her past history revealed a recent mental depression and a prior course of electric shock therapy for "mental disorder." A relative accompanying the patient stated that she was found on the kitchen floor in a pool of blood with the gas jet open, two empty medicine bottles by her side, and multiple lacerations of the wrists and neck. Emergency treatment administered elsewhere consisted of the application of sterile dressings and the insertion of a tracheostomy tube through an existing laceration in the cricothyroid membrane.

On admission to this hospital the patient presented a picture of circulatory collapse with blood pressure 50/38 mm. Hg and pulse rate 110 per minute, The bilateral wrist lacerations were multiple but superficial and without evidence of nerve or tendon loss. The neck laceration extended from the posterior aspect of one sternocleidomastoid muscle to the other and had severed all the pretracheal muscles. Hemorrhage had ceased, and the wound appeared contaminated with pharyngeal and tracheal mucus. In addition to the laceration through the circothyroid membrane, there was a second and smaller incision at the base of the epiglottis through which swallowed methylene blue dye was rapidly expelled.

Intravenous fluids, including 2000 cc. of whole blood, were infused, but the patient was not considered a suitable candidate for anesthesia until 24 hours had elapsed. At this time the wound showed early purulent exudate formation.

Dr. Freeark: I remember this patient as one who had been most persistent in her attempts at suicide. The wound had been inflicted in multiple swipes so that various sections of skin of the neck were involved. I do not know whether she lacerated through the cricothyroid membrane in addition to the base of the epiglottis or whether that was done at the other hospital, but she had the standard "high" tracheostomy wound. There was considerable delay in primary treatment, and after 24 hours the wound was grossly infected and contaminated. She had a laryngeal injury, perhaps of her own doing, perhaps on the basis of the emergency insertion of a tube. No major vessels were involved other than the external jugular vein.

Dr. Holinger: Here again there are a number of factors involved. Certainly the presence of a tracheostomy tube as high as this will cause trouble; so, as soon as possible, the first step would be to do a low tracheostomy to remove the tube from the vicinity of the cricoid cartilage.

and replace it lower in the trachea. In the past, performance of a tracheostomy through the cricothyroid membrane was very common. This point in the airway is the closest to the skin surface and the easiest point to do a tracheostomy with little equipment. If one simply puts a knife through the membrane and twists it sideways one can spread the cartilages and allow for immediate and rapid opening of the airway below the glottis. In laryngeal obstruction it is the simplest way to get in, but it is dangerous because a tube in this area causes destruction of the cricoid cartilage and often leads to the development of chronic laryngeal stenosis. So when the patient's condition permits, after blood replacement and shock have been managed, the first thing would be to do a low tracheostomy. The second is debridement and cleaning of the wounds and resuturing of the involved structure. Her upper incision at the epiglottis is probably responsible for the loss of fluids and saliva into the wound rather than the one at the cricothyroid level, but again it is important to know whether the esophagus is involved at any level. Ordinarily an incision that goes through the cricothyroid membrane will not involve the esophagus, and it is not impossible that both the sternocleidomastoid muscles may be severed. Strangely enough, in self-inflicted blade and knife wounds, the great vessels are very often spared.

With antibiotic coverage I would make an attempt to close the laryngeal and pharyngeal wounds, but such a repair requires adequate drainage. Because of the gross contamination, one may find that it is necessary to establish pharyngostomy which can be closed later by skin grafts. I think, even with the 24 hour delay, it may be possible to get a reasonable approximation of tissues which will ultimately close. I think the subsequent management of the laryngeal injury would depend on the degree of paralysis and deformity. If nerve and cord damage has occurred on only one side, it would probably not have to have any therapy, but bilateral cord paralysis would have to be operated upon. Again the possibility of cricoid stenosis here is relatively slight because the cricoid cartilage itself does not seem to be cut. A plastic procedure may be necessary later. If there is great destruction of the mucous membrane, it may be necessary to insert a mold or stent such as we talked about in the first case. If the esophagus is involved, this has to be managed by an attempt at approximating the lacerated edges as accurately as possible; but drainage has to be adequate.

Dr. Freeark: This lady had extensive debridement of the neck incision. The pharynx was closed, as was the wound in the cricthyroid membrane, with interrupted sutures. She developed a small pharyngeal fistula which closed spontaneously three weeks after surgery. She has undergone a number of plastic procedures, largely for the multiple scars, involving the area. The larynx turned out to be quite serviceable. Her voice is not entirely normal but the airway is clear. This entire episode apparently served as shock treatment because her depressed state has been continually improving.

Mr. Reading: There is an American author who wrote a short story about a man who, in a fit of deep depression, cut his throat. The resident worked hard and got friendly with the man and he recovered. On discharge the resident jokingly said to him, "Listen, when you cut your throat, don't throw your head back because you then throw your great vessels right back and you just cut your larynx. Keep your head forward." The man was readmitted that night, dead, having faithfully followed his advice.

Dr. Freeark: All of which lends support to the widely held opinion in this country — that residents talk too much.

Dr. Holinger: Patients who have attempted to commit suicide once will invariably try it again. While this patient seemed reasonably well, she requires constant observation because she is likely to be planning some other procedure and will go right ahead and try suicide again.

Dr. Freeark: Dr. Holinger, would you carry this discussion further and tell us something about the indirect or blunt type of trauma to the larynx?

Dr. Holinger: Injury to the larynx is very often seen in connection with auto accidents or the rapid transportation type of accident. Ordinarily the larynx is protected by the chin and chest. Injury coming from the front generally fractures the jaw or chest cage and the larynx is fairly well protected. However, in automobile or airplane accidents, or in streetcar accidents, injury occurs to the larynx because the

head is thrown back, the entire body is thrown forward and the larynx strikes the dashboard as the head goes through the windshield. This occurs most commonly to the front seat passenger and usually when the person does not have his seat belt fastened. It occurs in streetcars when the seat has a handle over the back; the person is thrown forward and his head strikes this handle on the seat in front of him. It occurs on the golf course when a golf ball hits the front of the neck, or in the ball park when the baseball bat comes around and hits the neck of someone standing near the batter, or in industry when an individual carrying a heavy object stumbles and falls, striking his neck on the object as his head goes back. It occurs from wires strung across a road. It can occur intentionally or entirely by accident. A child riding a bicycle or motor scooter can run into a wire across a street or lawn and can sever the larynx and trachea. Gunshot wounds of the neck may involve the larynx, trachea, and esophagus and are very destructive injuries.

Injury from within the larynx can occur by aspiration of hot gasses in a blast injury or while working in chemicals where the person inhales the fumes. Injury can occur from rough or prolonged endotracheal intubation, or from a naso-gastric tube that remains in contact with the posterior surface of the cricoid plate for a prolonged period.

What are the complications? There are two — respiratory obstruction and changes in the character of the voice. Both of these may be severe and may change the patient's entire life. Because of the very constant need of the voice and the manner in which it is used, it is an important personality asset. Changes in the voice are quite debilitating to the patient, not only physically but psychologically as well.

Injury may occur from edema, hematoma, paralysis of the vocal cords, or fracture of the cartilages themselves. The cartilages are very strong and heavy, but when they are fractured they collapse and the entire airway is changed and may actually be lost.

Suppose a multipe injury case comes in resulting from an automobile accident. The patient has been thrown forward. He has fractures of the jaw, chest, leg, and face. He may have a fracture of the larynx as well, but the other fractures take precedence. Tracheostomy is done, and when he is out of shock the other fractures are taken care of, but frequently the laryngeal fracture is forgotten. We should remember that fracture of the larynx is just as important to handle early as is the fracture of any other part of the body. There should be approximation of the parts in as anatomical a position as possible with splinting in a functional position. The larynx is a respiratory organ so we want to give the patient an airway which will be reasonably good and, if possible, will enable him to speak with the muscles of his larynx. So splint the larynx as soon as the patient's condition will permit. Everyone knows what to do about the patient who has a smashed nose: the structures of the nose are restored to good alignment and kept in position with splints. We have to do the same with the larynx when the crushing injury already has necessitated a tracheostomy. Expose the larynx under general anesthesia, through the mouth if possible, and insert a polyethylene tube or some other form of splint that can be fixed to the tracheostomy tube. Let it remain in place as long as necessary to maintain that airway. If the jaw is fractured and this cannot be done through the mouth, it can be done from below. The larynx can be opened, parts put in alignment, a splint put inside and the larynx closed. Unfortunately, what often happens is that the other fractures are taken care of and when the patient is ready to leave the hospital, somebody says, "What will we do about the tracheostomy tube?" and it is taken out. The patient cannot breathe because the larynx has healed in a closed position, and it will require months to correct it. It will take nine months to a year, and this could have been avoided if the original injury has been treated as any other injury.

What if there is paralysis of a cord associated with the cut-throat injury? This produces an interesting sequence of events. In the first place, unilateral recurrent laryngeal nerve injury results in one cord being flaccid and the other moving so there is vibration of one cord against a flaccid cord. It is so flaccid that phonation may be a very soft whisper. If both cords are paralyzed, they are paralyzed in a phonating position so that the patient's voice is better than with unilateral paralysis. This is something we have

to stress constantly because on occasion after thyroidectomy the patient can phonate and talk perfectly well, but he is having difficulty on inspiration because both recurrent laryngeal nerves have been cut. The character of phonation does not give a clue as to the degree of laryngeal nerve damage. It is necessary to look at the cords with a mirror and see each cord move on phonation and inspiration.

Now I would like to show some of my own slides. The first slide shows complete stenosis of the larynx (Fig. 1) following trauma to the internal larynx where cautery was used in getting rid of papilloma. Cautery should not be used in the larynx because it results in such scar formation. Here the scar tissue has pulled the cords together. X-ray shows complete stenosis in the laryngeal airway. The same problem occurs in all injuries to the larynx. Scar tissue contractures close the airway, and removal of all this scar with insertion of skin grafts is required later. Here a polyethylene tube will have to be inserted to keep the airway patent.

In an automobile accident injury to the larynx, a tracheostomy may have to be done. There may be tremendous emphysema around the larynx and up and down the pretracheal fascia from the base of the skull and to the bifurcation of the trachea. This destruction of the larynx requires tracheostomy first and later insertion of some type of mold or stent. These are the various types of molds that can be used (Fig. 2). Almost any type of polyethylene tubing can be used, cut to length with the ends sealed in a flame and a heavy suture passed through it and tied to the tracheostomy tube to anchor it.

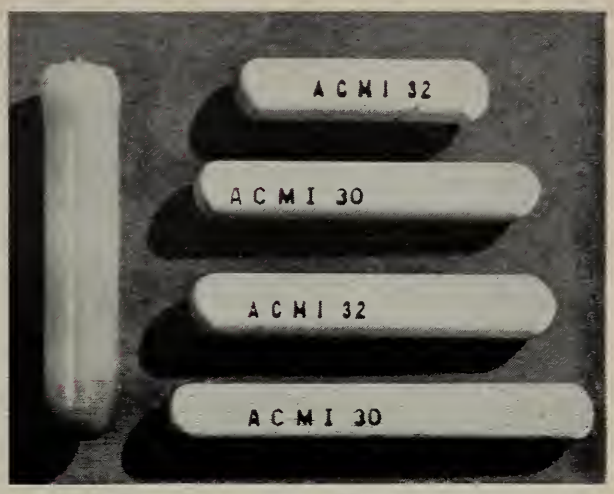


Figure 2. Types of molds used in repairing larynx.

In figure 3 we see the mold in place after em-



Figure 1. Complete stenosis of the larynx following cautery. Scar tissue has pulled cords together.



Figure 3. Mold in place, anchored by suture to the tracheostomy tube after automobile accident injury.



Figure 4. Anteroposterior collapse of the larynx.



Figure 5. Same larynx showing stenosis and pinpoint opening in the residual airway.

physema has subsided. It should remain in place for two or three months. It can be removed at times to be cleaned and to see how the patient is progressing. After the larynx has healed, the patient will have a reasonably good airway. There will be some loss of structure and the ordinary outline of the vocal cord will be completely lost; yet he is able to phonate. He will have a deep but acceptable voice and a good, serviceable airway.

This is an x-ray of a fracture of the larynx which had not been treated (Fig. 4). There was marked anteroposterior collapse of the larynx. The arytenoids are pushed way up and the entire larynx is foreshortened. This is a picture of the same larynx after the epiglottis has been lifted to show the stenosis (Fig. 5). There is just a pinpoint opening as a residual airway. All the scar had to be removed.

This x-ray was made following an opening of the larynx and insertion of skin grafts (Fig. 6). This is a mirror picture of the larynx with the stent in place (Fig. 7A). It shows the skin sutured around it. The foam rubber stent will be removed and the polyethylene tube put in its place. This is a later picture showing beginning epithelialization in the trachea (Fig. 7B), and figure 7C is a direct laryngoscopic view about four months after the graft was inserted. It shows the skin taking hold very well and yet if we remove the polyethylene tube at this time,



Figure 6. X-ray following opening of larynx and insertion of skin grafts.

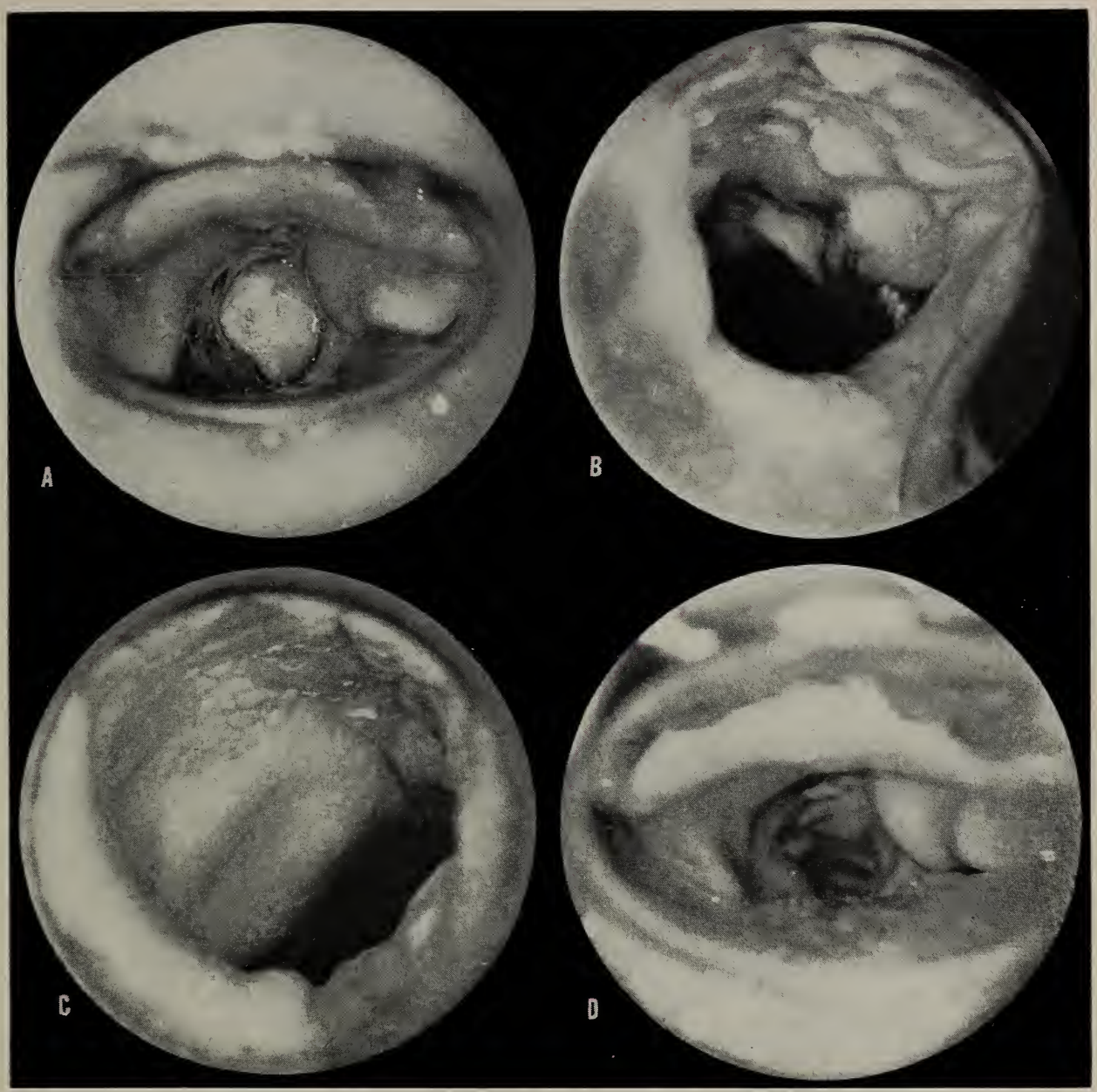


Figure 7. Progress of laryngeal repair: A—Larynx with stent in place. B—Beginning epitheliazation of the trachea. C—View four months after grafting. D—Larynx after nine months shows good result.

it will stenose again; so it is necessary to leave the mold in place. Nine months later one sees the skin surrounding the interior of the larynx and the patient has a good result. (Fig. 7D).

In summary there are certain points about laryngeal fractures that must be re-emphasized. Manage this fracture as one would any other fracture. Don't forget it. Handle it just as well and just as early, and a good result will be obtained which will avoid a lot of work and discomfort to the patient later.

MR. READING: This is not a common problem in England and I have nothing to add.

DR. FREEARK: Dr. Holinger, you and others have emphasized the importance of indwelling nasopharyngeal tubes such as the Levine or Miller-Abbott as a factor in injury to the pharynx and larynx. As I recall, these tubes ulcerate the mucosa by pressure, and the replacement of this necrotic area by scar tissue may prove disastrous to voice and airway. Are you certain that the polyethylene tubing you use as

a splint is not contributing to some of this scarring? It is entirely innocuous?

Dr. Holinger: The Levine tube causes damage because of pressure necrosis, infection, and collapse of the cricoid cartilages. The question is a very logical one, because we leave polyethylene tubes in the larynx for weeks and months as splints without apparent difficulty. But they are supporting the larynx from within. We know that ulcers will occur on the posterior part of the cricoid cartilage when the feeding tube gets in the midline and is squeezed. If you get it over to the side, there is less opportunity for this ulceration to occur. It is wise to get the feeding tube out or move it over to one side if it causes pain, preferably get it out.

Dr. Freeark: Apparently polyethylene is less irritating than rubber?

Dr. Holinger: It is, however, more rigid, and can cause ulceration.

Dr. Hinkamp: Is there a high percentage of takes in these skin grafts applied to the internal larynx?

Dr. Holinger: So far they have all taken, at least in part. We have not had to repeat any. You must realize that the cartilage may be so deformed that when the larynx is opened, one may not find the cords at all. Once you get into the lumen you have to take out large pieces of cartilage which are deformed and destroyed. You cannot just open up the lumen and put in skin grafts. A lumen has to be established and then the foam rubber mold is cut according to size, and it is tested and tried before the skin is sewed around it. But the destroyed cartilage has to be removed to established a lumen first.

Dr. Raffensperger: What do you recommend for people in areas where there are no specialists skilled in the endoscopic reduction of these fractures and injuries?

Dr. Holinger: Reduction over an intratracheal tube would be fine. If the fracture is in the trachea itself, one can put the tube entirely below the cords, but if it involves the cricoid, then the tube has to be placed higher, measuring ahead of time what length is needed. The x-ray will give an index as to position and length of splint necessary. The trachea is pretty big and can stand a good sized tube, but it does not have to be as big as normal to give the patient all the air he needs.

Question: Do you ever have trouble removing the tube after nine or ten months? Does the stoma in the trachea close promptly?

Dr. Holinger: Ordinarily a little plastic procedure is required to close the tracheostomy. Perhaps you are referring to the fact that sometimes after removal of a tube the patient becomes cyanotic with respiratory distress. There are many reasons for that. There may be a granuloma around the internal aspect of the stoma that has to be removed, or there is a residual stenosis of the larynx. Under those circumstances, an x-ray of the neck would help. Sometimes the tracheostomy tube causes granulation tissue farther down and makes trouble. Stenosis at the point of tracheostomy can occur. Lastly, a child with a tracheostomy for a long time is difficult to extubate because he is so used to the tube he will not breathe through his mouth.

Dr. Eugene Broccolo: What about laceration of the cricoid or thyroid cartilage alone?

Dr. Holinger: Such a laceration could simply be sutured, as was done in this first patient who was well sutured and did not need a tracheostomy. That was good approximation. However, I think both Mr. Reading and I would have rested more easily if tracheostomy had been put in.

Dr. Freeark: In previous conferences we have covered various aspects of the multiple injury patient. This excellent demonstration and discussion today has served to heighten our understanding of another very small but extremely critical area. Dr. Holinger, we greatly appreciate your coming here today and hope that you and Mr. Reading will visit us again soon.

Points to be remembered

1. Injuries to the larynx may result in rapidly fatal respiratory obstruction. They may exist alone, as part of a multiple injury accident, or in association with anesthetic or endoscopic manipulation, lye ingestion, or feeding-tube accidents.
2. Manifestations of laryngeal trauma are disturbances of the voice, respiratory stridor, supra and infrasternal retractions, and symptoms of anoxia. Depending upon the injury, bony or gaseous crepitation may be palpable.
3. When patient's condition permits, a lateral

x-ray of the neck and mirror examination of the larynx are extremely valuable for purposes of records and prognosis. Attempts to view the larynx in patients with impending respiratory obstruction may be hazardous. In patients with respiratory distress localized by the presence of retractions, stridor, and dysphonia a tracheostomy must often precede diagnostic study.

4. It is extremely important that tracheostomy be placed low, as far from the injured larynx as possible, in order to avoid loss of the cricoid ring through infection or further trauma.
5. Complete voice rest and steam inhalations are valuable adjuncts to the management of any laryngeal injury.
6. Prompt reduction of laryngeal fractures should be carried out when patient's condition permits. This may require internal manipulations, use of an intralaryngeal splint or open reduction through anterior neck incision.
7. The late result of failure to accurately reduce dislocated and fractured laryngeal cartilages is chronic laryngeal stenosis. The distressing degree of disability and prolonged rehabilitation required to correct it are largely preventable by prompt initial treatment and careful follow-up examinations of the injured larynx.

Age and prostatectomy

The most dangerous form of retention from the urologist's point of view is that which occurs in a man who is already ill in bed with some medical complaint such as pneumonia, bronchitis, cardiac failure, etc., because once retention has occurred, prostatectomy is generally necessary eventually. This raises the question: prostatectomy, early or late? When should one decide that a man with moderate prostatic symptoms should have an operation? Ironically enough there is little doubt that the fitter a man is the longer he can afford to delay. It is the poor risk patient who should have an early operation before he becomes any worse. Unfortunately this is the type of patient who is deferred, just because he is unfit. Great age in itself is no bar to successful prostatectomy, and while urologists are proud of their 90-year old patients, it is frequently forgotten that in order to live to 90 a man has to be tough, and many of these very old men stand operations very well indeed; infinitely better than a younger man who is medically unfit. *Howard G. Hanley. Discussion on Prostatectomy—Early or Late? Proc. Roy. Soc. Med. July* 1960.

Early Detection of Cancer of the Lung

Donald L. Paulson, M.D.* *Dallas, Texas*

THE TERM *early detection* as used for any cancer is misleading because it infers detection in a localized phase and implies a temporal relationship between early diagnosis and good results of treatment. Although present methods of diagnosis are not adequate for all cases, *early* radical excision of the cancer and its regional lymph-bearing area is considered potentially curative.

Poor results, due to dissemination, are explained on the basis that these patients arrived for treatment too late to obtain a good result. This temporal factor has been emphasized to such an extent that both the lay public and the medical profession often experience great difficulty in understanding that early dissemination and metastases occur with a rapidly growing anaplastic carcinoma and produce few or no symptoms at its primary site. Similarly, some of the excellent results of therapy—measured by long term survival—that are obtained in patients who have the longest histories of their disease and who arrive late for treatment are considered unusual.

Briefly, early detection does not necessarily result in diagnosis of an early localized cancer. An appreciation of the natural history of any cancer is fundamental to early diagnosis. The following observations illustrate various characteristics of the natural history of bronchogenic carcinoma.

Husfeldt[1] has found in Denmark that the operability rate for bronchogenic carcinoma is practically the same for those who come in early and those who arrive late for treatment. This apparent paradox can be explained on the basis that the more rapidly growing cancers produce progressive symptoms in a shorter period of time but are frequently inoperable. On the other hand, the more slowly growing tumors are accompanied by less pronounced symptoms but may still be operable when the patient finally presents himself for treatment late.

From a study of more than 10,000 cases McKenzie[2] found that the median duration of symptoms *decreased* with the *increasing* extent of the lesions at the time of diagnosis: 5.9 months for those classed as having tumors confined to the lung and 4.9 months for those with distant metastases.

Resectability and survival rates for bronchogenic carcinoma follow characteristic patterns when plotted against duration of symptoms before operation. Bignall[3] has found that the chances of successfully treating patients with lung cancer will be higher in those with either short or very long histories, and lower for those in intermediate range.

Resectability rates dropped from 61 per cent in the group of patients with no symptoms to 25 per cent for those with symptoms of less than a month, and 20 per cent for those with symptoms 1 to 11 months, but rose to 28 per cent for those having symptoms over one year. Bignall and Moon[4] found that, among 453 patients undergoing resection, the two-year survival rate varied from 53 per cent in those with symptoms for less than three months to 39 per cent in those with a six to eight months' history, and 54 per cent for those with symptoms a year or longer. The survival rates of untreated patients follow the same pattern. Bignall reports the one year rate fell from 25 per cent to 12 per cent as the duration of symptoms lengthened, but it rose to 17 per cent in the group with the longest histories. Similar variations of survival rates with the length

*From the department of thoracic surgery, Baylor University Medical Center.

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of history before diagnosis have been reported for cancers at other sites.[5]

It is obvious that factors other than time have an important bearing on the course and prognosis of cancer. The biologic traits of cell type, location, and resistance or immunological response of the host are significant. The variegated pattern of behavior and prognosis in bronchogenic carcinoma depends on the biologic characteristics of the neoplasm. In our series,[6] in 35 per cent of the patients having bronchogenic carcinoma, the initial complaint that prompted the patient to seek medical advice indicated distant metastases, or the lesion was inoperable because of cell type. In these patients the obscure nature of the primary anaplastic lesion and its rapid growth, with early progression to dissemination, make diagnosis and treatment practically impossible during a localized phase. In contrast, the well differentiated epidermoid or adenocarcinomas may remain well localized for long periods of time, produce few or no symptoms, and yield long periods of survival after resection. To diagnose such lesions earlier is to increase survival time even without resection.

A cancer may be early biologically but late chronologically. The observation that a particular lesion is symptomless may give the impression that it is an early lesion in point of time, but this may or may not be true. The fact that it may remain localized and symptomless for a long period of time, in some cases for years, is a direct expression of its biologic character. Its eventual growth to produce symptoms or disseminate depends on its cell type, the resistance or immune response of the host, and its original location. The phrase "detection in an early or localized phase" is therefore preferable to "early detection" with its chronologic connotation.

Survival is calculated from the time the diagnosis is made, but in many cases retrospective study of roentgenograms of the chest of patients with bronchogenic carcinoma reveals the lesions to antedate either the symptoms or diagnosis for long periods of time, two years or more.[7]

The pulmonary nodule

The most favorable location for a bronchogenic carcinoma—from the standpoint of detection in an early localized phase, resectability, and prognosis—is a pulmonary nodule. By definition, it is roughly spherical, of soft density but may contain calcium, and surrounded by lung tissue on all sides. Its border may be notched, irregular, or nodular. Because of its location in the contrasting lung parenchyma, its roentgenographic shadow may be readily detected during a symptomless phase and when it is only a few millimeters in diameter. Eighty per cent of these lesions in our experience are resectable, in most cases by lobectomies. This is in contrast to an over-all resectability rate of 35 per rent for all types of bronchogenic carcinoma, half of which require pneumonectomies. The five-year survival rates following resection of 95 patients having a bronchogenic carcinoma presenting as a pulmonary nodule are 50 per cent for the entire group but 40 per cent of those producing symptoms, and 65 per cent for the asymptomatic or silent lesions. Forty per cent of pulmonary nodules due to bronchogenic carcinoma are asymptomatic in our experience. Unfortunately only roughly 10 per cent of bronchogenic carcinomas present themselves as pulmonary nodules. These survival rates far surpass the over-all 22 per cent five-year survival rate following resection of all types of bronchogenic carcinoma.

When the pulmonary nodule is the original location, 50 per cent are epidermoid carcinomas, and 30 per cent are adenocarcinomas. Very few of these lesions are of the large cell, undifferentiated type, and the small cell (oat cell) type occurs only rarely. Eighty-seven per cent of the patients with silent adenocarcinomas presenting as a pulmonary nodule survive five years. Nodal involvement was found in only 25 per cent in contrast to 70 per cent for the over-all lung cancer group.

Localized low grade hilar lesions

Localized low grade hilar lesions are usually suspected because of symptoms of pneumonitis or hemoptysis. They may be detected in an early phase by roentgenograms or planograms that often show the small shadow of increased density in or near a lobar or segmental bronchus together with a segmental or lobar obstructive pneumonitis. Bronchoscopic examination, because of the location of these lesions, is highly productive of confirmatory evidence either by biopsy or cytologic studies of aspirated secretions.

Because low grade hilar lesions are slowly invasive and do not metastasize until late in their course, lobectomy or lobectomy in combination

with a sleeve resection of the main bronchus and bronchial anastomosis often constitutes an adequate operation. The radical procedure of pneumonectomy for this type of lesion is unrealistic because it ignores the biologic character of the carcinoma and the practical considerations of function.

Results available to date for lobectomy in combination with bronchoplastic procedures for low grade hilar lesions indicate survival rates of 86 per cent at two years, 71 per cent at three years, and 43 per cent at five years.[8] These figures are in a range similar to the results of resection for the nodule due to bronchogenic carcinoma.

Twenty-four of our 51 patients surviving five years following treatment for bronchogenic carcinoma had hilar lesions, and in 18 the neoplasm presented as a pulmonary nodule.

Conclusion

The chances for successful treatment of patients with lung cancer today are highest in those without symptoms and in those with short or long histories, and lowest for those in intermediate range. Because of the biologic factors involved, early detection is not possible under present limitations of diagnosis in all cases, but detection by roentgenography in an early phase of the biologically favorable lesions is feasible. Routine roentgenograms of the chest are necessary to detect the pulmonary nodule and low grade hilar lesions and should be included in every physical examination, hospital admission, and employment examination. Detection in an asymptomatic phase usually indicates a localized lesion, resection of which yields as high survival rates: 65 per cent at five years for the pulmonary nodule, and as high as 87 per cent for the asymptomatic adenocarcinoma.

Present methods of diagnosis are not adequate for detection in a localized phase of biologically unfavorable lesions which grow rapidly and disseminate early, often in the absence of symptoms at the primary site. These lesions occur in about 40 per cent of cases. Under these circumstances, care should be taken not to unjustly incriminate the unfortunate patient or his physician for delay in diagnosis. It is reasonable to assume that by concentration on the more favorable types of bronchogenic carcinoma that occur in 60 per cent and the consequent detection of these lesions in a localized phase, improvement in survival rates after resection may result.

REFERENCES

1. Husefeldt, E.: Carcinoma of the Lung. Johan Holst Memorial Volume, University of Oslo, Norway, p. 119, 1955.
2. McKenzie, A.: Duration of Symptoms, Clinical Staging and Survival in Cancer of Certain Sites, Brit. J. Cancer 10:401, 1956.
3. Bignall, J. R.: Natural Duration of Bronchial Carcinoma, Lancet 2:210, 1955.
4. Bignall, J. R., and Moon, A. J.: Survival after Lung Resection for Bronchial Carcinoma, Thorax 10:183, 1955.
5. Härnett, W. L.: The Relation between Delay in Treatment of Cancer and Survival Rate, Brit. J. Cancer 7:19, 1953.
6. Paulson, D. L., and Shaw, R. R.: Early Detection of Bronchogenic Carcinoma, J.A.M.A. 146:525, 1951.
7. Rigler, L. C.: Duration of Carcinoma of the Lung, Dis. Chest 23:50, 1951.
8. Paulson, D. L., and Shaw, R. R.: Results of Bronchoplastic Procedures for Bronchogenic Carcinoma, Ann. Surg. 151:729, 1960.

Rosen's operation

Otologists showed only mild enthusiasm for Rosen's operation at first because they believed that the nature of the pathologic process in otosclerosis made it almost inevitable that refixation of the stapes would occur. Because of its simplicity, however, many recommended the operation as a preliminary procedure to the more formidable fenestration operation. Otosclerotic patients reacted to the operation with enthusiasm and, as knowledge of it spread, more and more deafened persons demanded it. It has probably been performed well over a hundred thousand times in the United States. *Harold G. Tabb, M.D. Trends in Surgery for Otosclerosis. J. Louisiana M. Soc. August 1960.*

Trends in the Care of Glaucoma

Max Hirschfelder, M.D., *Centralia* .

Glaucoma in its various forms is a universal disease confronting to an equal degree the ophthalmologists of urban and rural areas. While research and advancements in this field have obviously been carried out in the large urban medical centers, the results have benefitted many patients who never see a glaucoma clinic at a university hospital and who rely often in unquestioned confidence, especially in smaller towns, on the advice and judgment of their individual ophthalmologists. To show the approach to the problem in these glaucoma patients, as it is handled in my own practice located in a rural and small town area, is the purpose of this paper.

Acute glaucoma

Twenty-five years ago there were basically two types of glaucoma, at least on the nonacademic level. One was the acute inflammatory type in the patient who came to us with acute pain, a red eye, sudden loss of sight, a dilated pupil, and a very high intraocular tension. In contrast was the second type then called "chronic simple glaucoma." The patient frequently lost considerable central and peripheral vision without being aware of the impaired function. Moderately elevated tension, glaucomatous cupping of the optic nervehead, gradual shrinkage of the peripheral field, and enlargement of the blind spot were the indications. Naturally, today these same basic types and their symptoms and objective findings are still with us, but we have learned a great deal more about them.

Originally acute glaucoma was thought to be merely an exacerbation of the chronic type. It was thought to be one in which control was lost through the influence of vasomotoric and neurogenic abnormalities, possibly triggered by emotional factors and governed through impulses originating in the hypothalamus. Sudden congestion of the vessels in the choroid, a throttling off of the vortex veins, and edema of the vitreous increased the intraocular pressure, according to these early theories of acute glaucoma. The iris was supposed to be pushed forward secondarily by these events, and the angle of the anterior chamber became shallow due to them.

Diagnosis and management

Our present day understanding, based primarily on facts found by gonioscopy, attributes an attack of acute glaucoma to an existing narrow chamber angle. This narrowness is a primary cause, not secondary as was formerly presumed. The acute incompensated glaucoma is today the so-called angle closure glaucoma built up on a predisposed narrow angle anatomy.

Recognition of a narrow angle before it can lead to an attack of acute angle closure, the immediate reduction of the acute increase in pressure by more powerful drugs, and the final prevention of an attack by surgical means are the trend developments of the late forties and fifties. A narrow angle can be suspected from the history of temporarily blurred vision, or it may be seen at simple inspection under the beam of a slitlamp. It has been demonstrated that the tonometer will show perfectly normal values before there is an actual angle closure. Tonography, likewise, as Grant[1], Becker[2], and Scheie[3] have shown, will show normal or nearly normal outflow facilities before an attack or in the controlled intervals between attacks. But if we are circumspect enough we can ascertain the narrowness of an angle in a given suspect patient by gonioscopy with the lens of Barkan, or the gonioprism of the Thorpe-Allen or Goldman types. Should suspicion remain, then we can at least ascertain—in a certain percentage of cases —the possibility of angle block by the iris root through so-called provocative dilation of the pupil, either in a darkroom test or after the use of a mild mydriatic. In this connection it is interesting to recall that in the early thirties the late Harry Gradle had practiced tonometry be-

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fore and after dilating the pupil. The results of tonography will usually show a decrease in the facilities of outflow in eyes which have a dangerously narrow angle; a dangerously low level of these facilities will lead us to recommend prophylactic surgery. It certainly will make the use of miotics mandatory.

Medical means for controlling an acute attack have been enhanced also beyond the means we had twenty years ago. Then we had the older miotics like pilocarpine and eserine. We could reinforce their action by intravenous administration of hypertonic solutions of dextrose or sorbitol which reduced fluid in the eye through osmosis. Today we are greatly aided by the introduction of such carbonic anhydrase inhibitors as Diamox® or Daranide®. These agents, as Becker[4,5] had shown, decrease the secretory function of the ciliary body by as much as 50 per cent. By administering local pilocarpine with oral or intravenous Diamox, it is usually possible to reduce the intraocular pressure to normal limits relatively early in an acute attack. This is particularly true if the patient is seen during the first few hours, or the first day, before extensive peripheral synechias have developed. Lately the use of hypertonic urea, a 30 per cent solution which comes under the trade name Uretrit®, has been added to our means of reducing intraocular pressure in cases that do not respond to other means. This is a more effective treatment by osmosis than the older hypertonic sugar solutions of the thirties.

After the tension has been reduced to normal in an angle block glaucoma, a peripheral iridectomy is now the accepted procedure following the attack. This view has not always been held. However, in the middle thirties Gifford[6], in his small textbook of ophthalmology, recommended surgery as soon as the tension had been normalized, but it was Chandler[7] who later repeatedly forcefully pointed out that narrow angle glaucoma is basically a disease for surgical treatment.

If an acute attack has persisted for several days or if peripheral synechias impair the facilities of outflow as shown by tonography, then an iridencleisis may be more effective than the simpler procedure of peripheral iridectomy. Becker[2] recommends an iridencleisis when facilities of outflow as shown by tonography are less than 0.15; if they are normal during periods of control, a peripheral iridectomy is preferable.

Wide angle glaucoma

The second type of the primary glaucomas, the so-called chronic wide angle glaucoma formerly called glaucoma simplex, was usually recognized only in the fairly well established cases. Certainly, once in a while a patient who had retained good central visual acuity and a full field was fortunate enough to consult a conscientious ophthalmologist who routinely took the intraocular pressure with a tonometer. And if this case showed a pressure of 26 or 28 or higher, further investigations were carried out. But by and large, until about ten years ago, many of us were quite prone to rely on the general and very deceiving impression of our two index fingers during the routine examination of a patient. Having satisfied ourselves by this rather crude and most unreliable method — as a blind study of tactile tensions at the Illinois Eye and Ear Infirmary under the direction of Dr. Peter Kronfeld has shown — that the "tactile tension" was soft, many a case was dismissed with good acuity, good disc, and good field only to return a few years later with definite irreversible glaucomatous changes.

Naturally, we frequently still see patients who on the very first visit to our offices have obvious signs of wide angle glaucoma; deep cupping of the disc, poor central vision, and constricted fields are the giveaways even before a tonometer is put on the eyeball. These glaucoma patients were not recognized before damage could assert itself, either because of their own neglect, the insidiousness of this disease, or, all too frequently, the negligence or inexperience of examiners at the time of a simple visit for refraction. They may still be helped, but it is unfortunate that someone had not labeled them at least glaucoma suspects before the manifest clinical signs became glaring irreversible facts which needed tonometry only as a matter of record for later reference rather than for case finding and diagnosis.

The Schiotz tonometer is the primary tool for finding glaucoma in the unsuspecting patient and for the unsuspecting doctor. Though Goldmann's applanation tonometer may take its place in our offices in future years, the older Schiotz tonometer still is the most widely used instrument. We are told that one in fifty office patients over 40 have, or are candidates for, wide angle glaucoma. Naturally, if tonometry reveals defi-

nitely high pressure, field studies, especially blind spot studies, will help us to evaluate the case and to control it by treatment. In the past decade it has become more and more obvious that certain pressure readings may be normal for one person and pathologic for another. We also are aware of the diurnal variations of intraocular pressure, particularly through the studies of Thiel and of Duke-Elder. Few of us have facilities to check these occasional pressure rises in the early morning hours. So how can we handle, under the pressure of our daily patient load, suspect glaucoma cases with borderline normal tensions of 23 to 25 mm. Schiotz? These patients frequently have normal vision, normal discs, normal fields, and a normal blind spot. We also may have evaluated this factor of scleral rigidity by taking the pressure with two different weights to see if there was a marked difference between using a low weight and a higher weight.

The following history may be instructive for such a case: Mrs. L. L. had a pressure of 25 mm. found after a routine refraction. The angle was open in each eye. All other findings were normal. Provocative dilation did not raise the pressure, and the figure of 25, while somewhat high, was certainly low enough to have been missed by the old tactile tension routine. Maybe 25 mm. was normal for her? But it also could be early glaucoma. There are several ways to handle such a patient: continued observation of acuity, disc, and central and peripheral field is the oldest one. It involves a great deal of patience on the part of the physician, an intelligent and cooperative patient, the clinical facilities, and, especially in a busy practice, the time for taking repeated and accurate fields at least three to four times a year.

In this country central field tests with small objects have received increasing emphasis because an enlargement of the blind spot is among the earliest signs of damage from wide angle glaucoma. Even a relatively early peripheral constriction is said to be demonstrable on the tangent screen if one investigates the isopters lying between the point of fixation and 30 degres with a test target at 2,000 mm. distance. Goldmann's[8] clinic in Bern developed the technique of investigating a given isopter on the bowl perimeter under strictly standardized adaptation and background illumination and presenting a given target under various light intensity.

Provocative tests, particularly the one of comparing tension before and after the intake of one quart of water within an hour interval in a fasting patient, frequently give clues that make definite glaucoma cases out of suspect ones. It is said that a rise of over 6 mm. by tonometry is diagnostically significant.

Leydecker[9] recently described more accurate provocative tests with the vasodilators injected subconjunctivally. The pressure rise from sympathetic stimulated vasodilation is said to occur in 90 per cent of wide angle glaucoma cases. In practice this test may not be as popular and as commonly employed as the much simpler water-drinking test. The same may be said for the venous pressure test whereby a sphygmomanometer cuff around the neck is blown up to 45 mm. mercury. Added to these examinations and often combined with provocative tests is tonography.

We in the St. Louis area have been able to utilize for our private patients the facilities of the Washington University Glaucoma Clinic and its tonography laboratory.

There are authorities like Scheie[10] who consider tonography primarily a research tool rather than an aid for the practitioner and his patient. In my own practice, through facilities of the eye department of Washington University, it has become an important tool for evaluating the borderline patient and, up to a point, to confirm the efficiency of medical treatment.

Treatment

As the trend in treatment of narrow angle glaucoma has been directed toward surgery, treatment of wide angle glaucoma has become more conservative during the past decade. Many a case of wide angle glaucoma designated for early surgery 20 years ago can now be kept under medical treatment and the certain dangers inherent in any intraocular surgery avoided. It is no longer true, as it was said in the early forties by Algernon Reese[11], that an early filtering operation is the surest way to prevent deterioration of central and peripheral sight. It is also no longer true, as expressed in Chicago about fifteen years ago, that one operates on the glaucoma patient in his sixties for the relief of tension and fifteen years later for the lens opacity that frequently follows glaucoma operations.

The reason that we can be more conservative lies (a) in our earlier diagnosis through tonom-

etry, tonography, and gonioscopy, and (b) in the availability of drugs which not only help us to increase the facility of outflow but also inhibit secretion of aqueus from the ciliary body. To the older miotics like pilocarpine hydrochloride and eserine salicylate have been added cholinergics like Carbachol® and cholinesterase inhibitors like echothiophosphate (Phospholine Iodide®) and demecarium bromide (Humorsol®). The latter two have the advantage of being more powerful so that they can be given less frequently than the older miotics.

The research work of Hamburger[12] and in this country of Gradle[13] concerning the beneficial effect of epinephrine and related substances, especially when given in conjunction with miotics, has been re-emphasized recently for use in wide angle glaucoma. They had fallen in disrepute because in the pre-gonioscopy days they were mistakenly used in narrow-angle type glaucomas and induced acute attacks. Now, since we can differentiate narrow angle from wide angle glaucomas, their use in conjunction with miotics has been recommended.

Finally, starting with the work of Becker in 1953[4,5], the effects of secretory inhibitors like Diamox®, Cardrase®, Neptazane®, and Daranide® were investigated, and these drugs became useful and widely used tools for long range therapy in many of our more stubborn glaucoma cases. We are cognizant that all these drugs, local as well as parenteral ones, are powerful and may have side effects which make their use impossible. We also realize that their use does not mean that we can leave the patient to himself for very prolonged periods; he has to be supervised and evaluated every few months at the very least. This also does not mean that surgery in wide angle glaucoma can be relegated to history in cases which show progressive deterioration of field and vision in spite of these new drugs, and in whom it is impossible to lower the intraocular pressure to acceptable limits. So, we shall continue to have to do iridencleises or trephines or sclerectomies. However, the indications for such operations are less frequent than in the past.

The ultimate solution of the glaucoma problem is still not at hand. It will be solved only if science eventually solves the secret of the aging process. And this may be a Utopia which may never be reached.

Summary

Narrow angle glaucoma and wide angle glaucoma can be diagnosed before the classical, clinical signs become evident and before permanent damage to the structures of the eye and to its function has taken place. Routine tonometry, provocative tests, gonioscopy, and tonography are valuable in establishing an early diagnosis. Continued observation of the visual field and the blind spot are important, especially in patients with wide angle glaucoma who have poor facilities of outflow and whose disease is under questionable control.

Acute angle closure can be relieved in the majority of cases by miotics, carbonic anhydrase inhibitors and, if necessary, intravenous urea. However, relief of the acute attack by medical means should always be followed by peripheral iridectomy or, in the face of poor facilities of outflow, by an iridencleisis.

Wide angle glaucoma does not require surgery as frequently as formerly. More powerful miotics, the judicious use of epinephrine derivatives, and carbonic anhydrase inhibitors keep the function of many eyes with wide angle glaucoma from deteriorating. There are, however, still patients who do not respond to even strong conservative measures and in whom a fistulizing type of glaucoma surgery must be considered.

REFERENCES

1. Grant, W. M.: Clinical Tonography, Tr. Am. Acad. Ophth. (Nov.-Dec.) 1951.
2. Becker, B. and Thompson, H. E.: Tonography and Angle Closure Glaucoma Diagnosis and Therapy; Am. J. Ophth. 46:305, 1958.
3. Scheie, H. G., Spencer, R. W., and Helmick, E. D.: Tonography in the Clinical Management of Glaucoma, A.M.A. Arch. Ophth. 56:797, 1956.
4. Becker, B.: Decrease in Intraocular Pressure in Man by a Carbonic Anhydrase Inhibitor, Diamox, Am. J. Ophth. 37:13, 1954.
5. Becker, B.: Diamox and the Therapy of Glaucoma, Am. J. Ophth. 38:109, 1954.
6. Gifford, S.: Textbook of Ophthalmology. Philadelphia, W. B. Saunders, 1939.
7. Chandler, P. A.: Narrow Angle Glaucoma, A.M.A. Arch. Ophth. 47:695, 1952.
8. Goldmann, H.: Demonstration unseres neuen Projektionskugelperimeters samt theoretischen und klinischen Bemerkungen ueber Perimetrie, Ophthalmologica 111:187, 1946.
9. Leydecker, W.: Provocative Tests in Glaucoma; Glaucoma: A Symposium, edited by W. S. Duke Elder, Springfield, Ill., Charles C Thomas, 1955.
10. Scheie, H. G.: Symposium on Glaucoma, edited by Clark; St. Louis, C. V. Mosby, 1959.
11. Reese, A. B.: Early Operation in Glaucoma, J.A.M.A. 113:1204, 1939.
12. Hamburger, C.: Ersatspraeparate fuer Adrenalin und ihre Bedeutung fuer die Glaucomabehandlung, Med. Klin. 21:1497, 1925.
13. Gradle, H. S.: The Use of Epinephrine in Increased Intraocular Tension, J.A.M.A. 84:675, 1925.

CASE REPORTS

Concomitant Pulmonary Schistosomiasis And Tuberculosis

Charles K. Petter, M.D.*, Kenneth L. Morris, M.D.†,
Emanuel Anawis, M.D.†, Gerald B. Dean, M.D.‡, and Donald Fox, M.D.‡

Schistosomiasis is a tropical disease caused by certain species of trematodes which pass an essential part of their life cycle in certain snails.[5] Where the snails exist in stagnant or slow running water, it is possible to find these trematodes. Eggs passed in the feces of a human host gain access to the water and develop into motile larvae that invade the snails. After their cycle in the snails, tadpole-like forms, cercariae, escape into the water. They burrow into the skin of bathers and enter the blood stream, where adult worms develop and live chiefly in the abdominal veins. Schistosome infestation generally becomes manifest clinically as hematuria or as rectal bleeding accompanied by eosinophilia,[4] pain, fever, a swollen, tender liver, and prostration.

It has been estimated that 60 to 70 per cent of the inhabitants of Egypt are infected with schistosomasis, and the disease is endemic in certain other parts of the world. *S. hematobium* is the common parasite in the Nile Valley, Portugal, and the Middle East and is the cause of vesical schistosomasis. The *S. japanicum,* causing intestinal and hepatic schistosomasis, is found predominantly in China, Japan, and the Philippine Islands. *S. mansoni* infection is common in Puerto Rico and certain parts of Venezuela.

In all probability, schistosomasis in North America is found only in persons who have been in endemic areas. With the great influx of Puerto Ricans to our larger centers of population there is a good reason to assume that cases of schistosomasis may become clinically evident.[6]

In their elaborate paper dealing with pulmonary schistosomasis, A. F. Bernard Shaw and A. Abou Ghareeb, discuss meticulously the various forms of infecting organisms and the resulting disease.[2]

About one-third of persons infected with schistosomasis manifest pulmonary involvement, as shown in one of their series of 282 autopsies.[1] The number of ova circulating through the pulmonary vascular bed is the deciding factor in determining the type of pulmonary tissue response. It has been stated by Shaw and Ghareeb that in 87 per cent of cases only a few ova have entered the lungs.[2] In this situation the lesions present were parenchymatous tubercles. Embolic ova rarely are seen in these cases. Where infestation is heavier, vascular lesions as well as tubercles occur and embolic ova are frequent. Healing of acute vascular lesions leads to an obliterative arteriolitis.

*Superintendent and Medical Director and
†Assistant Medical Director, Children's Memorial Hospital
‡Pathologist
Lake County Tuberculosis Sanatorium, Waukegan, Ill.

Massive and repeated infection of the lungs is followed by widespread arterial changes, hypertrophy of the right ventricle, and the development of the cardiopulmonary features of Ayerza's disease with death from congestive heart failure (2 per cent[2]).

Report of a case

In 1957 we had occasion to see a 29 year old Puerto Rican (five years removed from Puerto Rico), because of weakness, cough, some expectoration, and thoracic pain. His medical history was essentially negative in that he denied any previous illness. One brother had received treatment for tuberculosis in New York, and our patient had been exposed to him.

Our patient was 66 inches tall and weighed 140 pounds but had lost 10 pounds in 2 months. Blood pressure was 130/70, pulse rate 76—rhythm regular, body temperature 99° F. There was some impaired resonance over the left upper third of the chest with suppressed bronchial breathing but no rales in the same area. Heart tones were clear. The general physical examination was otherwise normal.

The tuberculin test was positive, and a blood study showed:

Hemoglobin	12.6 Gm.
Hematocrit	41%
White count	5400
Neutrophils	65
Lymphocytes	26
Monocytes	7
Eosinophils	2
Sedimentation rate	65 mm./hour.

Chest x-ray on Sept. 17, 1957 revealed soft mottling in the right lung at the level of the second anterior interspace, and in the left lung a large annular shadow above the second rib with infiltration above and below.

The sputum showed acid-fast bacilli on direct smear.

A diagnosis of pulmonary tuberculosis, moderately advanced, was made; and sanatorium management — bed rest, antibiotic and chemotherapeutic measures — was instituted. Dihydrostreptomycin was given 1.0 Gm. twice weekly with isonicotinic acid hydrazide 100.0 mg. and para-aminosalicylic acid 4.0 Gm. three times per day. Progress was good. Sputum cultures were last positive on Nov. 1, 1957. Planograms of the left apex on Nov. 15, 1957, revealed a residual cavity.

By March, 1958, planograms showed a dense fibroid mass at the site of the previous stellate cavity. Bronchoscopic examination revealed a definite endobronchitis involving the left main and upper lobe bronchi. This had cleared at examination April 15, 1958. A left apical posterior pulmonary resection was done on April 17 and postoperative recovery was uneventful. The patient was discharged on May 17 still receiving dihydrostreptomycin and isonicotinic acid hydrazide. He is well and working at the time of writing.

Examination of the excised lung was reported as follows:

"Diffuse atelectasis and severe fibrosis. There are numerous fibrocaseous nodules surrounded by varying amounts of lymphocytic reaction. In addition, there are numerous peculiar nodules of chronic inflammation and fibrosis surrounding foreign cellular material. Examination of one of these latter nodules showed a longitudinal section of a parasite that has the anatomical characteristics of *S. mansoni*.

"Conclusions: 1. S. mansoni of lung, left apex, diffuse, severe. 2. Chronic fibrocaseous tuberculosis of lung, left apex, diffuse. 3. Atelectasis, bronchiectasis, and fibrosis of lung, left apex."

This man has been examined and questioned on several occasions over the past year without eliciting history of a previous illness that could have been attributed to schistosomiasis. A review of chest x-rays made before and since operation do not reveal any of the vascular changes reported by Erfan and Deeb[3] as being characteristic of this infestation. Perhaps we should give the patient a course of antimony and see if it is possible to increase pulmonary reaction such as Erfan and Deeb[3] describe following such therapy.

REFERENCES

1. Abdel-Aziz, Sami: Pulmonary Manifestations of Schistosomiasis, Dis. Chest 19:698-705, 1951.
2. Bernard Shaw, A.F., and Ghareeb, A. Abou: The Pathogenesis of Pulmonary Schistosomiasis in Egypt with Special Reference to Ayerza's Disease, J. Path. & Bact. 46: 401-24, 1938.
3. Erfan, H., and Deeb, A.A.: The Radiologic Features and Chronic Pulmonary Schistosomiasis, Brit. J. Radiol. 22: 638-642, 1949.
4. Vishwanathan, R.: Non-Tuberculous Diseases of the Chest. Edited by Andrew L. Banyai. Springfield, Ill., Charles C Thomas, 1954. Pp. 325-326.
5. Bell, E.T.: A Text Book of Pathology. Philadelphia, Lea and Feabiger, 1956. Pp. 521-522.
6. Jung, Rodney C.: Broncho pulmonary Diseases. Edited by E. A. Naalerio. New York, Paul B. Hoeber, 1957.

The View Box

Franz Gampl, *Chicago*

A 23 year old, colored male came to the admitting room complaining of recent onset of shortness of breath and chills accompanied by some exertional dyspnea.

The history revealed scarlet fever at the age of 5 and occasional nonradiating substernal pain over the last 12 month period.

The patient was in moderate respiratory distress. The blood pressure was 110/74. The pulse was 102 per minute, regular and equal; and the temperature, 100.2°F. Rales were heard over the posterior aspects of the lung fields during both phases of the respiratory cycle. There was no dullness to percussion. The heart was enlarged 13 cm. to the left of the midclavicular line. The apex beat was felt at the sixth intercostal space. A grade III systolic and grade II distolic murmur were audible over the apex. The liver was palpated two finger breadths below the costal margin. There was no ankle edema.

The patient was sent for a chest roentgenogram.

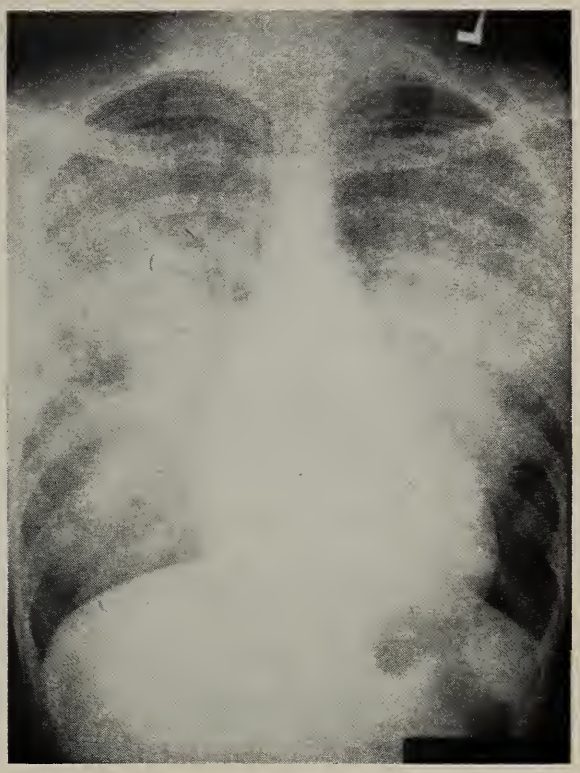


Figure 1

Differential diagnosis
(1) Atypical pneumonia
(2) Acute, pneumococcal pneumonia
(3) Acute, alveolar pulmonary edema
(4) Massive pulmonary tuberculosis

(*continued on page* 359)

Mechanization and man

Today one hears much of the amazing potential machines have for increasing and improving the dissemination of scientific information. Indeed, the science of documentation does promise exciting rewards. But no amount of electronic mechanization can eliminate the need for trained and skilled manpower and its products. At least in the foreseeable future, machines cannot substitute for subject matter knowledge and editorial finesse; the intellectual tasks will still have to be done by human beings. As information increases in quantity, the strains on manpower resources will still rise sharply; an illogical competition for personnel will arise between organizations that develop scientific information (laboratories and clinics) and organizations that process the information and turn it back to the development areas. *Richard H. Orr, M.D., and Don M. deKoven. The Summary—The Most Used and Most Neglected Part of Scientific Papers. J. Albert Einstein Med. Center. Oct. 1960.*

MEDICINE IN THE OUT-OF-DOORS

This is to be a monthly feature of easy, informative reading. Every physician will recognize the material; it's not new — it's the setting that differs. With his inclination for the biological sciences, pre-med and medical training, he will see much of the column as "old hash." But it will be slanted to the out-of-doors with emphasis on preventive medicine wherever possible; perhaps it will have some basic physiology, botany, entomology, first aid in the field, and other aspects of his previous education now somewhat dimmed with the passing years. No originality of material is claimed and no earth-shaking pronouncements will be made.

For the out-of-doors minded physician, and his patients of like bent, his attention will be called to new equipment, clothing, and the like, to make his lengthening leisure time more fruitful. But the precise technique for tying a fly or pin-pointing the mountain meadow where a prize elk resides will be left to the conventional outdoors magazines. This is how the column is conceived. Comments and criticisms are invited. *The Editor*

The Under-pinning

Julius M. Kowalski, M. D., *Princeton*

One of the most abused and neglected parts of our anatomy are the feet. Being relatively stable structures, we do not as much as look at the feet until a disease process begins or complications develop.

But the active pursuit of outdoor activities demands feet and lower extremities which are conditioned to withstand sustained as well as immediate violent effort. So seldom have our feet failed us that we accept this all important quality without further thought.

The fine balance between health and disease of the feet can be quickly upset by stressful conditions of fall and winter. The high school and college boys who spent all summer at manual labor to develop muscles of the back and upper extremities in preparation for football and basketball now discover ingrown toe nails, blisters, exacerbated dermatophytoses and shin splints. Their fathers and older brothers, more sedentary with advancing years, just might spend a few hours at the local skeet or trap club grounds to get the feel of the old shot gun and put the shooting eye into the groove in anticipation of the coming hunting season. A small but enthusiastic group of individuals hopefully look toward a good ice skating season or deep fluff snow to cover their favorite skiing slopes. Even the lonely ice fisherman, as he methodically assembles his gear, dreams of the huge northern that will take his chub this winter. But none of these, young and old alike, have given much thought to the feet.

The swivel-hipped, speedster halfback will be sidelined with an ingrown toe nail that could easily have been treated in August. The promising hook-shot basketball center will spend agonizing nights with hot packs on his shins. Several months of rope skipping and moderate running could have helped him to league honors. Dad will come home after the first day afield or from slogging through a duck marsh with his "dogs" literally barking and severe leg cramps which won't permit his weary body to rest. Sis will be walking on turned in ankles after the first ice, or won't get her regular shoes on because of puffy ankles following a day on the ski slopes. The ice fisherman, as he soaks his feet that first

night hoping to restore some feeling in them after a day of stomping, still clings to the gossamer of hope that the big northern will be his the next time out.

All these recently exuberant but now pain-racked persons could have been spared by a little forethought on their part or a few words of caution from their family physician. Though a thorough examination of the legs and feet takes little time, it often is neglected, and only a few quick questions are asked the patient in this regard because it takes too long to take off the shoes and socks and put them on again. The lower extremities can be conditioned by simple exercises, but it takes *doing* on the patient's part to have them withstand anticipated stresses.

In this era of two cars in every garage, we should rediscover the art of walking. It is good medicine for young and old when practiced regularly. All muscles will increase in tonus, pulmonary exchange will increase, cardiovascular stimulation will be invigorating, abdominal cramps will be dispelled, and flatulance will be left in the breezes. Pathology of the feet and lower extremities, if any, will present itself usually in such a manner that corrective measures can be applied without significant loss of time from work or undue distress.

Socrates could ask questions best of his colleagues after a long walk into the Athenian countryside. Wordsworth drew inspiration for his sonnets by daily traversing the hills and dales of England. And Dr. Paul Dudley White even today walks or rides a bicycle.

Ten more days to Christmas.

The View Box —diagnosis and discussion (*continued from page* 357)

The chest roentgenogram reveals an enlarged cardiac shadow with straightened left heart border. The shadow of the aortic arch is small, and there is a faint double density behind the cardiac shadow representing an enlarged left atrium. The lung fields show fine to coarse granular, symmetrical perihilar infiltrations. The costophrenic angles and upper lung fields are clear. These findings were interpreted as compatible with mitral heart disease and diagnostic of alveolar pulmonary edema.

The pulmonary edema cleared on bed rest as shown in the roentgenogram (Fig. 2) made 36 hours after admission. The patient was digitalized and discharged on maintenance doses of digitalis.

Pulmonary edema may have many etiologies:

1. Left heart failure
2. Acute pneumonia in the hyperemic stage
3. Allergic conditions:
   a. Collagen diseases
   b. Loeffler's pneumonia
   c. Hypersensitivity reactions
4. Toxic conditions
   a. Uremia
   b. Toxemia of pregnancy
   c. Inhalation of noxious gases and fumes
5. Diseases associated with hyponatremia and hypoproteinemia

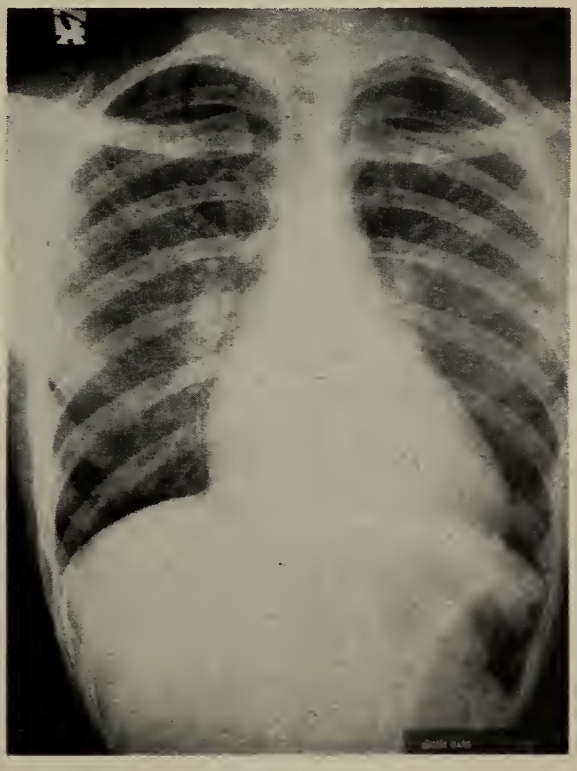


Figure 2

6. Neurologic conditions
   a. Cerebrovascular accidents
   b. Brain tumors
7. Drowning
8. Hydremia (over-hydration)

EDITORIALS

The followers of Luke

Christmas commemorates the birth of Christ, the Great Healer who enabled the blind to see, the crippled to walk, and the bedridden to rise. His work was carried on through His disciples, the art of healing particularly through Luke, the "beloved physician." And so today, the good physicians are filled with compassion for humanity and constantly seek to understand illness, pain, and death. The followers of Luke, and all others who care for the sick, should never hesitate to ask for divine guidance in solving the problems at hand. The great physicians were humble, as exemplified by Pare's words, "I dressed his wounds; God healed them."

The Bible has offered more relief and consolation over the centuries than all our modern drugs combined. There are many suggestions in this great Book that every physician could use with excellent results. Much benefit, for example, could be derived from the familiar words of Isaiah, "Fear thou not; for I am with thee." Many people derive reassurance from the thought that their God is with them when they are ill or a member of the family is in critical condition. Their confidence increases when the physician harbors the same feeling. Religion plays a powerful role in promoting a hopeful attitude.

New frontiers in the prevention and treatment of mental retardation

Of the 4,200,000 human beings who will be born in the United States in the coming year, 126,000 will not reach the mental age of 12 years, 12,600 will not reach a mental level of 7 years, and 4,200 will be helpless idiots. These are government statistics. To put it in another and less pessimistic way, 30 of every 1,000 people in our country are mentally handicapped. Twenty-five are educable, four are trainable, and one is permanently and completely dependent. That this is a challenge to the medical profession is evident when one considers that 50 to 80 per cent of all mental illness is preventable or is amenable to improvement or cure.

Nowhere in the United States are there adequate facilities either for prevention, treatment, custodial care, or for adequate identification of the mentally retarded. In Illinois the shortage of adequate hospital and custodial facilities, while lessening, is still a serious problem. The Chicago Public School system, with the oldest and one of the best departments of special education and child study in America, is able to identify only about half of the mentally retarded pupils and has facilities for giving special education to only about three-fourths of those identified. Too many parents still feel that a mentally retarded child is a family stigma and try to hide the child from the community. These "back-bedroom children," many with good learning potential, deteriorate into hopeless idiocy for lack of adequate management.

As recently as ten years ago, many physicians looked on mental retardates as intellectual runts, specimens of human wastage, rather than patients with preventable or treatable clinical entities. Institutionalizing them has often been the only possible advice to give to parents. But recent advances in etiology and definitive diagnosis and treatment promise to improve immeasurably the outlook for these patients. Herman Yannet, M.D., director of the School for Mental Retardation at Southbury, Conn., recently stated that in 1950 he could identify the cause of mental deficiency in only one of 100 of his pupils; today, in close to 50 per cent.

Breakthroughs have occurred along many fronts. The introduction of tranquilizing drugs, which find their greatest use in functional mental disorders, has been a major factor in shortening the average hospital stay of mental patients, and has permitted home treatment for many who previously were necessarily restricted in institutions. Advances in brain surgery have made

possible the removal of scars, and the improvement of blood supply to the brain in some cases. There is increasing success in regeneration of neurons. For example, axones have been grown on tissue cultures. In the newt, fibers of the cut optic nerve have been stimulated to regenerate to the point of making connections with the proper endings in the sense organ. Some of this research is already finding clinical application in the improvement or cure of mental deficiencies.

Probably the most significant clinical advances are occurring in the field of enzymes and genes. Genetic factors account for about 50 per cent of institutionalized patients with mental disease. Each enzyme is under the control of a specific gene. Mutations and other abnormalities of the genes can, therefore, by modifying enzyme action, produce a wide variety of abnormal conditions in the body. Of these inborn errors of metabolism probably the best known to physicians is phenylketonuria, which accounts for about 1 per cent of all mental retardation. Also familiar are galactosemia, Wilson's disease, and congenital agammaglobulinemia.

Of about 70 inborn errors of metabolism identified as specific clinical entities, about 20 have mental retardation as a part of their picture. Such workers in the field as Nobel Laureates Joshua Lederberg, Wendell Stanley, and Linus Pauling have succeeded in altering genes almost at will, and then restoring them to normal states. This is the beginning of the control of life processes themselves, and is highly significant. Dr. Pauling predicts that within 50 years we will be able to produce enzymes synthetically, the ultimate triumph over these diseases.

Another important advance is the identification of conditions leading to retardation at an increasingly early age. In phenoketonuria, for example, mental retardation can be avoided if the diagnosis is made before the age of four months and a diet low in phenylalanine is instituted. In hypsarrhythmia, mental deterioration has been avoided by the use of ACTH in the first year of life. In brain injuries the significance of perinatal anoxia, maternal diet, and other pre- and postnatal influences are being increasingly recognized and met. Samuel Karelitz recently described significant qualities in the cry of the infant during the first few days of life as an added indication in the early appraisal of mental development and mental potential.

To utilize the new knowledge of the causes, prevention, and treatment of mental retardation, we need more hospital beds, more trained personnel, more research, more mental health clinics, and more schools for the mentally handicapped — both day schools and boarding schools. We must support bond issues that make possible expansion of our state hospital's facilities. We must work for the establishment of clinics by local health departments, hospitals, and medical schools.

There is an increasing awareness of the need for more study. In the report of the Children's Bureau Clearinghouse for Research in Child Life, nearly four times as many studies concerned with mental retardation have been reported in the years 1956-58 as in the years 1948-51 — 151 in contrast to 42. Much of the increase is due to large federal funds appropriated for research — disbursed largely through Office of Education contracts with state departments of education and with universities. The National Institute of Mental Health also continues a widespread support of research in this field.

These federal grants reflect an increasing public interest that is taking tangible form throughout the country. This fall, for example, within a week two excellently organized and administered schools for the mentally retarded were dedicated in the Chicago Area — Little City, near Palatine, and the Therapy Center for the Mentally Handicapped in Michigan City, Indiana. Both of these schools were built on donated ground, of donated material, and largely by donated labor. They are inspiring examples of the ability of communities to meet their own needs without recourse to foundation funds or to state or federal aid.

The successful management of handicapped children in these schools, if they are to be more than custodial centers, depends on the concerted efforts of educators, clinicians, researchers, and social scientists. The practicing physician has an important part to play. Standards for institutions and other facilities designed for the care and training of the mentally deficient have been recommended by the American Academy of Pediatrics and are available from its central office. The recommendations can be of considerable help to the local physician who has little experience in organizing or administering these facilities.

Thus far, physicians generally have not assumed the leadership or given a significant amount of cooperative effort in this area. This situation must be remedied. We cannot permit programs so largely medical to be administered by nonmedical personnel. Nor should we be backward in a moment which so dramatically demonstrates the idealism, the public service, the helpfulness, and the unselfishness on which the medical profession is founded.

John Lester Reichert, M.D.

Modern treatment of nasal and sinus infections

The protean manifestations, etiologic factors, routes of extension, pathologic differentiation, and combinations of clinical pictures of nasal and sinus infections are of interest to the generalist and the specialist as well. There has been no change in the basic knowledge of the importance of the anatomical configurations including the venous and lymphatic channels, fascial planes, foramina, apertures, dehiscences and perineural sheaths. Nor have the basic physiologic requirements for a normal functioning nose, both primary (respiration, olfaction, air conditioning, and phonation) and secondary (humidification, temperature adjustment, air cleansing or filtration, ventilation, drainage, and its role as a resonating chamber) changed.

The vascular richness of the external as well as the internal nose emphasizes its relationship to local, systemic, and intracranial infections and hemorrhage. The venous channels are open and ready to convey organisms from foci around and in the nose to the cavernous sinus if ill-advised manipulation of even the most innocuous looking furuncle is perpetrated.

While it is true that the anticoagulants and antimicrobial agents are usually effective in combating what was formally a death-dealing complication, cavernous sinus thrombosis, prevention looms as the most important objective. There are few places in the body harboring the number of organisms caught up by the vibrissae in the vestibule of the nose, supposedly offering "the first line of defense" but not against the digital onslaught of man.

The requirements for normal nasal function consist of a large surface area (turbinates), a moist surface (mucous sheath) and glands which keep it so, ciliary movement, correct heat supply by cavernous spaces which are neither contract nor engorged, proper biochemical composition (pH 6.5) of nasal secretion, and an adequate pathway for aeration of the nose. Conditions which bring about alterations of those norms, whether by lowered resistance in the presence of the "cold" which does not clear up, acute infections, debilitating, allergic, endocrinological or deficiency diseases, trauma, foreign bodies, dental infections, swimming, and especially diving may predispose to nasal accessory sinus involvement. Knowledge of the causative factors aid the physician in pin-pointing the therapeutic attack to fit the individual patient, supplying the basic ingredients of restoring normal nasal aeration and adequate drainage, on the premise that something more than a bacterial infection is involved in such a process.

Self-diagnosis and treatment, encouraged by current advertising technics, oversimplify the problem and frequently lead the patient to neglect. Unfortunately, sinal spaces fail to respond in accordance with schematic representation. Medication which is selected to shrink tissue frequently has such a rebound reaction as to adversely cause mucous membrane to swell and further block the ostia leading to the sinuses. Other types of medication may interfere with normal ciliary activity or alter the biochemical composition of nasal secretion.

Total patient care, supportive and nutritional, together with local measures that tend to restore normal physiological functions of the nose, are in order, for both acute as well as for chronic sinus disorders. In the subacute phase, if the sinuses (such as the frontal, maxillary, or sphenoid) are affected by a suppurative process, they may be irrigated though their natural ostia or by negative pressure. Frontal and maxillary involvement may be ascertained by transillumination, but it must be borne in mind that about one-third may appear clear (false negatives) and yet yield pus or mucopus on irrigation. X-ray studies are more conclusive grounds upon which to base a diagnosis. Attention is directed to the role of dental infections in relation to maxillary sinus disease. In such instances both the sinal and dental infections require treatment.

In chronic sinus disease an investigation of the systemic factors (allergic states, endocrine and dietary imbalance, and general hygiene) and

the local mechanical factors (deviations of the septum and polyps) is necessary. Should the sinuses not respond to supportive general and local therapy, conventional roentgenograms (lateral, Water's position, antero-posterior view, sitting to bring out fluid level) may be supplemented by studies in which filling defects may be demonstrated by radiopaques to bring out such irreversible changes in the mucosal lining. Results of studies may call for a surgical consideration.

The form of surgery depends upon the sinus or sinuses affected. So very frequently, sinus involvements are multi- rather than unisinal, and the therapy to be successful must be directed accordingly. Surgical approaches (in a number of sittings) may be intranasal (maxillary, frontal, ethmoids, and sphenoids can be so entered) or external (frontal, ethmoids, and maxillary [sublabially]). The external procedures permit wide exposure for complete inspection and removal of pathologic tissue, including mucoceles and osteomas. The presence of polyps demands removal of the offending allergen and desensitization. Cortisone preparations may have a temporary favorable effect upon polyps but should not be contemplated as the sole therapy. Polyp removal in aspirin sensitive persons may result in status asthmaticus. Polyps, especially if unilateral, may be of the single choanal type originating from the middle meatal area, but if fleshy, may be suspected of being the readily bleeding angiofibroma or some other type of benign or malignant neoplasm. Only the microscope can answer this question and only then can the correct surgical approach be planned. Primary surgical adequacy is essential even in benign tumors of the nose and nasal accessory sinuses.

Finally, a note of caution which concerns both the medical and surgical sides of the sinus problem. Unfortunate abuses exist in both areas with overtreatment and too much surgery in the picture. Naturally, if a patient does not respond favorably to adequate nonsurgical therapy, it is unwise to overlook the favorable benefits of correct surgical management. It is to be hoped that all physicians will base their therapy on this fundamental knowledge.

Francis L. Lederer, M.D.

The opening wedge

The American Podiatry Association gave a citation to Dr. Morton H. Walker for his research paper that was delivered at their annual meeting. He reported beneficial results with Chymar® Ointment in over 97 per cent of 380 patients troubled with a variety of foot and leg disorders. According to a news release from Armour Pharmaceutical Company, the conditions included: corns, calluses, local abscesses, allergic dermatitis, inflamed nail grooves, ulceration of electrocautery, epidermophytosis, paronychia, and onychia, insect bites and stings, neurodermatitis, heel fissures, ulcers of various types, small acute wounds, and inflamed bunions and bursitis.

Another podiatrist reported on the intra-articular injection of Chymar Aqueous in the treatment of arthritic joints of the foot and toes. He used the same method to treat sprains, strains, fractures, and "painful toes of unknown causes." This is what's known as stereotyped symptomatic therapy.

Sooner or later the foot doctor will reach higher and higher, first treating diseases of the thigh, then disorders of the perineum followed by ailment of the pelvis, abdomen, chest, upper extremities, neck, and finally the head. When this time comes, some wise guy will announce that he is starting a school (or profession) for those who want to specialize in corns and calluses to help the millions of people suffering from painful feet.

Growth of power

The policies and procedures used by the Food and Drug Administration in reaching decisions concerning the acceptance and certification of new drugs was carefully studied by a special committee. The group selected for detailed study 29 applications covering 3 preparations of certifiable antibodies, 14 of antibiotics classed as new drugs, and 12 of other new drugs. This sampling, admittedly small, was considered adequate to provide reasonable conclusions.

They found that the way the FDA now makes decisions was acceptable considering the limitation of authority, funds, and scientific personnel. They found no evidence of disregard for the public health. They concluded, however, that

certain weaknesses inherent in the existing law hampered the FDA. In addition, there were certain deficiencies in the quality and quantity of the data upon which conclusions were reached.

They recommended that the FDA should be given statutory authority: to receive proof of the efficacy as well as the safety of all new drugs; to require manufacturers of new drugs to maintain records and submit reports of clinical experience and other relevant data before and after the drug is released for sale; to apply certification procedures to all antimicrobial agents used in the prophylaxis and treatment of infectious diseases.

They recognized the importance of preparing drugs under the highest standards of quality control and recommended proposals to clarify and strengthen existing inspection authority and to require that all drugs be manufactured and packaged under adequate controls.

They believed also that information supplied to physicians concerning drugs should be accurate and complete. The advertising of pharmaceuticals should be more carefully regulated than that of products unrelated to the prevention and cure of diseases. They also recommended that a careful study be given to the problem of coordinating the supervision of labeling, promotional material and other advertising of drugs. These problems are now divided among several agencies of the government.

The application for a new drug should contain a summary of the conclusions, the names and opinions of those involved, and such other data as may be necessary to provide a concise record of the basis for the decision.

There were other recommendations of an administrative nature that will not be mentioned.

It has been most interesting to watch the FDA expand and acquire more power and stature as a government agency. It did so by bringing the need for reforms before the people through publicity. The next step was to select this special committee to make the recommendations to the secretary of Health, Education and Welfare. In many instances the committee goes into the meeting "cold" and must be told by the administrator what problems exist, how they can be rectified, and what will be needed to assure enforcement. Ninety-nine times out of 100 they will listen to the bureaucrats because they are closer to the problem.

The last step requires Congressional action. It is here that the citizen gets his opportunity to voice an opinion through his congressman. There are many ways legislators alter the original bill to strengthen or weaken the proposal. One of the meanest tricks is to pass the bill but not to appropriate the funds to administer it.

During the past decade the number of bills related to the practice of medicine have increased steadily. It is an indication of public dissatisfaction, greed, or pressure from left wing elements. It will affect every physician, and none can complain unless he participates in some way to fight or support the issues at hand.

Correspondence

Dear Dr. Hesseltine:

WE DID IT!

With your help and the help of other wonderful, dedicated people around Illinois, we succeeded in getting approval of the Mental Health Bond Issue—an accomplishment most professional political observers thought impossible.

I believe that the tremendous majority our Bond Issue received demonstrates beyond any doubt that the voters of Illinois will recognize their responsibilities when they are given the facts.

You should be proud of the part you played in bringing these facts to the attention of the voters. Without this, our cause would have failed and the 50,000 patients and thousands of dedicated staff members would again have to face —without hope—the twin spectres of fire and disease.

I am honored to have been Chairman of this Committee. Above and beyond the pleasure of success, I have had the warm and rewarding experience of being associated in the best of causes with the best of people. My warmest thanks.

Sincerely,
Arnold H. Maremont, Chairman
Emergency Committee for
50,000
Chicago

AT THE EDITOR'S DESK



Counterfeit Drugs

The FDA warned druggists to be on the alert for counterfeit drugs. They are frequently delivered to the pharmacy in paper or pliofilm bags or other unlabeled containers, usually readily distinguishable from authentic wholesale packages. This underground, bootleg type of operation is on the increase. Counterfeit Diuril and Hydrodiuril have been seized.

There is no way to attest to the manufacturing, sanitation, and laboratory controls of these drugs. Some may have the same strength and purity of the drug it counterfeits, but there is no way the druggist can be sure. This information is passed along to our readers for their information and cooperation.

"Half-Way Houses"

The Veterans Administration is considering the establishment of more "half way" houses for recovering mental patients in communities where its hospitals are located. The patient lives outside the hospital while learning to readjust to community life. There is some supervision, but most of the patient's activities are at his own discretion. It is most suitable for schizophrenics who have been hospitalized for a long time.

The English make use of the half way house for all hospital patients who are recovering and do not need the care and attention of a battery of nurses and other skilled attendants. It is economical and rehabilitating.

The VA also is opening a Day Center at their West Side Hospital in Chicago. It will be used to help the psychiatrist complete the convalescence of mental patients, aiming at rehabilitation and resocialization. It helps the timid and insecure patients who are not quite able to meet the outside world. They will live at home and be encouraged to bring their lunches. The Day Center will maintain a club atmosphere (without the bar and tab to sign — we hope).

Foundation Hospital Poses Problem

The Brain Research Foundation recently took over the former Chicago Memorial Hospital on the South Side. It will cost $500,000 to remodel and equip the building. They expect to use it as a center where patients with brain disorders can be treated, according to their brochure, "with maximal efficiency — where knowledge of the best methods of treatment can be developed, tested and taught." Their field includes the following brain disorders and related illnesses — epilepsy, cerebral palsy, encephalitis, feeblemindedness, insanity, multiple sclerosis, cerebral arteriosclerosis, parkinsonism, drug addiction, alcoholism, mental retardation, psychosis, migraine, and neurosis.

The aims of this organization are beyond reproach, but their fund-raising propaganda may create unfair competition for neurologists, psychiatrists, and generalists. They cannot advertize their office as the place "where patients with brain disorders can be treated with maximal efficiency." This may be the handwriting on the wall for the practicing physician.

Vaccination for influenza

Routine vaccination against influenza for persons with cardiovascular or pulmonary diseases is being urged by the American Heart Association and the U.S. Public Health Service. A study of excess mortality during the epidemics of 1957-1958 and the first quarter of 1960 indicates that the excess of deaths occurs among older age groups and among those with chronic illness. Cardiovascular-renal diseases exacted a heavy toll.

Vaccination is urged also for persons with diabetes mellitus and Addison's disease, for pregnant women, and for all persons 65 years or older.

Since influenza epidemics recur in cycles of unpredictable periodicity, annual immunization for high risk groups is being recommended.

Pharmaceuticals

Riker Laboratories are marketing ULO (chlophedianol hydrochloride), a new non-narcotic antitussive agent. It is promoted as "being equal to the narcotics in power to suppress cough," and "one teaspoonful (25 mg.) suppresses cough for 4 to 8 hours. . . . . .Thus, one bedtime dose will usually carry a patient through a night of uninterrupted sleep, an achievement thus far unobtainable from non-narcotic antitussives."

Time will tell.

Searle recently introduced Lomotil, which is claimed to be an entirely new therapeutic entity for the control of both acute and chronic diarrhea. It inhibits excessive gastrointestinal propulsion. It is structurally related to some narcotic drugs and requires a narcotic order form.

In addition, Probital is Searle's new rational gastrointestinal antispasmodic. It is a brand of propantheline bromide with phenobarbital. According to our calculations, Probital is a new name for the old standby, probanthine with phenobarbital.

Enduron (methyclothiazide) is Abbott's new entry into the oral diuretic field. They claim the new drug has a duration of effect of at least 24 hours, thus affording satisfactory therapy with just one dose daily. In addition, 10 mg. produces as great a natruresis as the peak effect of any benzothiadiazine. The usual adult dosage ranges from 2.5 to 10 mg. once daily. For the maintenance of an edma-free state or as an adjunct in the management of hypertension, 2.5 to 5 mg. once daily usually is sufficient.

From the ACS Congress

More on automation: An automative device that permits rapid measurement of blood volume was described at the recent clinical congress of the American College of Surgeons. As usual, it does the job faster and better than the manual techniques now in common use.

Two new lightweight surgical masks were shown at the same meeting. The masks are made by the Minnesota Mining and Manufacturing Company, and are said to be capable of 90 per cent bacteria filtration. Both are made in a single size to fit any face and are disposable.

How Freud's Library Reached U.S.

The story of how Sigmund Freud's library was whisked out of occupied Vienna in 1939 after he had fled Austria is recounted in The Stethoscope, publication of Presbyterian Hospital in New York. The collection of 814 titles is part of the library of the New York State Psychiatric Institute of Columbia-Presbyterian Medical Center.

In July, 1939, the late Dr. Jacob Shatzky, the institute's librarian, read in a bookseller's catalogue "Books and Pamphlets on Neurology and Psychiatry. . .brought together in nearly 50 years by a famous Viennese scientific explorer . . . .The reduced total price is 1,850 German marks."

The astute Dr. Shatzky surmised that the Nazis would destroy all that belonged to Freud because he was a Jew and a psychoanalyst and that one of the occupying force saw a chance to make some money. He hurriedly sent off a check and directed the bookseller to emblazen the packing crates with swastikas to discourage German officials from checking contents as they passed through occupied territory before shipment.

Dr. Shatzky's gamble worked. In September when he opened the crates, he found many books so rare that they are unobtainable. Freud had put his signature in 54 of them, and many others bear marginal notes in his handwriting.

The collection is maintained in a wood-paneled, six by ten foot room endowed by the late Dr. A. A. Brill, Freud's English translator.

Tubercular Testing

Hospital admission films have not become a routine procedure even though the practice was pushed by some authorities. It is just as well, considering the current and past medical concern on radiation exposure.

On the other hand, there is no doubt that routine chest x-rays of those admitted to the average general hospital would uncover cases of active and suspect tuberculosis as well as other chest abnormalities. According to Dr. George T. Wohl of Philadelphia, the yield of unsuspected cases would be four to eight times higher in this type of survey than in those conducted by the community. This could be done safely provided good radiation protection practices were followed. One exception, mentioned by Dr.

Wohl, is the routine chest x-ray in children. Skin testing offers a better way to detect early tuberculosis in this group.

Translating Maimonides

Dave Meade of the Chicago Daily News carried a story on the medical manuscripts of Maimonides, great Jewish philosopher-theologian-physician of the Middle Ages. Dr. Morris Fishbein and other interested parties are promoting a project to have these manuscripts translated into English and modern Hebrew. This monumental job should throw new light on medical history and research.

Mobiles

We love catalogues, and the latest, "Mobility is the Answer," demonstrates the various products of Medical Coaches, Inc. This company brings Health-on-Wheels® in a variety of mobile units varying from ambulances to diagnostic centers. Their Imperial, for example, is a custom built trailer, 43 feet long and 8 feet wide. It houses an examination center, including space and equipment for a complete physicial examination, vision and hearing testing, tonometry, electrocardiogram, chest x-ray, and a completely equipped laboratory. They also have special trucks for dental clinics and veterinarians and a mobile dispensary for government physicians in the Indian Service.

A country doctor or traveling specialists might get an idea or two from this catalogue.

Yum-Yum

Adolph's research laboratories have discovered three new seasonings that may help the low sodium dieter. They are a seasoned salt substitute and garlic salt and onion salt substitute.

Warning Label for Dihydrostreptomycin

New labeling requirements to assure the safe parenteral use of dihydrostreptomycin were proposed by the FDA. The outside wrapper or container would bear the statement "Warning: For use in patients who cannot tolerate streptomycin." This is done because of the drug's potentiality for causing delayed deafness. Severe auditory damage has been reported following a total parenteral dose of as little as two to five grams of dihydrostreptomycin. The damage may be delayed for weeks or months but is permanent when it develops.

Mixtures of dihydrostreptomycin and streptomycin should be administered only to patients having tuberculosis amenable to treatment with one or both of the drugs, but who cannot tolerate full doses of streptomycin.

Schizophrenia and Heredity

The incidence of schizophrenia in the general population is 0.85 per cent, but in the family of the schizophrenic the incidence is dramatically higher. In siblings, for example, it is 14.2 per cent, whereas in identical monozygotic twins it is 86.2 per cent. When one parent has the condition, the incidence in children is 9.1 per cent; 53 per cent when both parents have it.

More Full Time Professors

There is a definite trend toward a larger proportion of full time faculty in medical schools in a continuing effort to elevate standards of medical education. In 1951 one out of every four faculty members held a full time appointment. In 1960 the proportion increased to one in three. According to Datagrams, full time refers to geographic as well as strict full time. The numbers increased from 4,000 to 11,000, while the number of medical schools increased from 79 to 85. But despite the increase there remained 655 budgeted unfilled full time faculty positions.

Doctors' Pension Plan

Two midwest groups were able to devise pension plans that were approved by the District Director, Springfield, Illinois. According to a recent news release on Prentice-Hall Doctor's Tax Report, the physicians employed themselves and put part of their income into "cold storage" — tax free — to be taken out when their need will be greater and the tax bite smaller.

Physicians cannot incorporate, but these clinic physicians set up their professional practice so that it will be taxed as a corporation. The physicians became employees of the clinic. Ac-

cording to the release, the government reasons "what looks and acts like a corporation should be taxed as a corporation."

Our recommendation for others: Get expert assistance before you decide to form a group for the sake of a pension plan.

Two Are Better Than One

Army supported studies conducted by Dr. Alf S. Alving of the University of Chicago have demonstrated that a combination of chloroquine and primaquine is more effective against malaria than the drugs used separately. The combination tablet will be used in Korea, where it should receive adequate testing. The new treatment procedure for military personnel in malarious areas will be the administration of one of the new tablets each week.

Anticoagulants and Infarctions

A group from the cardiovascular department of Pennsylvania Hospital in Philadelphia have seen 20 cases in which acute myocardial infarction recurred following the abrupt withdrawal of oral anticoagulant therapy. Bishydroxycoumarin was used most frequently. They conclude that anticoagulant therapy after clinical recovery should be maintained in the average patient for at least 6 to 8 weeks after ambulation. But when therapy is to be withdrawn, the dosage should be reduced very gradually, preferably over a period of 4 weeks or longer. They also advise weekly prothrombin times to guide the reduction of dosage.

Cholesterol and Coronary Heart Disease

It may take another decade to settle the relationship between high blood cholesterol levels and coronary heart disease. There appears to be mounting evidence on the therapeutic side that once a heart attack occurs, there seems to be no relationship between survival and the concentration of fats in the blood. Dr. Robert D. Roe of Toronto followed a group of 120 male survivors of coronary thrombosis free of other complicating diseases. Sixty per cent were alive at the end of five years, and the survival rates were identical in those with high and those with low cholesterol levels.

Hypoallergenic Pillow

A new urethane foam bed pillow, which is washable and hypoallergenic, is now available for those allergic to dust, feathers, and kapok. It can be washed easily in the home laundry, is extremely resilient, moth proof, mildew proof and odorless. The pillow will be marketed under the name of "Slumber Rest" and the manufacturers want us to know that "the sleeper doesn't wake up with a pain in the neck."

Implanted Pace Maker

A miniaturized electronic cardiac pacemaker, completely implanted beneath the skin, has been used successfully on patients with complete heart block. The device, including its batteries, is the size of a pocket watch and has an estimated lifetime in excess of five years.

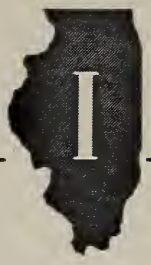
Jet Safely

During the past eight years the passenger death rates in United States scheduled airlines were less than 1 per 100 million passenger miles. There have been no deaths among passengers of jet planes since they were put into service nearly two years ago.

In science, read by preference the newest works; in literature, the oldest. The classics are always modern. — *Lord Lytton*

Many have no happier moments than those that they pass in solitude, abandoned to their own imagination, which sometimes puts sceptres in their hands or miters on their heads, shifts the scene of pleasure with endless variety, bids all the forms of beauty sparkle before them, and gluts them with every change of visionary luxury. — *Johnson*

ANNOUNCEMENTS



Cardiovascular seminar

The annual Cardiovascular Seminar, sponsored by the Northeast Florida Heart Association, will be held at the Prudential Auditorium in Jacksonville January 26 through 28, 1961.

The participating physicians are Dr. William Dock, professor of medicine, New York State University; Dr. Lewis Dexter, assistant professor, Harvard University Medical School; Dr. Milton Rosenbaum, professor and chairman, department of psychiatry, Albert Einstein College of Medicine; Dr. Richard Ebert, professor and chairman, department of medicine, University of Arkansas School of Medicine.

Further details and programs may be obtained by writing Daniel R. Usdin, M. D., President of the Northeast Florida Heart Association, 1628 San Marco Blvd., Jacksonville 7.

ACOG elects new president

Dr. Nicholson J. Eastman, Baltimore, was chosen president elect of the American College of Obstetricians and Gynecologists at their October meeting in Chicago, filling the vacancy created by the death last April of Dr. Herbert E. Schmitz, Chicago. Dr. Eastman has been professor of obstetrics at Johns Hopkins University and obstetrician-in-chief to the Johns Hopkins Hospital for the past 25 years.

Course in radiation physics

Again this year all interested physicians may register in the annual course in radiation physics for residents in radiology at the hospitals associated with Northwestern University Medical School.

It will be given on Monday evenings 6:45 to 9:00 p.m. January 2 through May 15, 1961, at Veterans Administration Research Hospital, 333 E. Huron St., Chicago.

The tuition fee for residents is $25; for physicians, $50. Applications should be sent to Registrar, Northwestern University Medical School, 303 E. Chicago Ave., Chicago 11.

Edward Loveland dies

Edward R. Loveland, Philadelphia, died October 23 at the age of 67. He was the executive secretary of the American College of Physicians from 1926 until he retired last January, and the only layman ever made an honorary fellow of the organization.

PHS creates state services positions

Three U.S. Public Health Service positions have been created.

Dr. James M. Hundley, as an assistant surgeon general, will take up responsibilities in the areas of field relationships with regional medical directors, of health mobilization, and of international health.

Mr. Harry Hanson and Dr. Aaron W. Christensen have been named associate chiefs of the service's Bureau of State Services, with the rank of assistant surgeon general. Dr. Hanson will function in the area of environmental health activities, and Dr. Christensen will be concerned with community health services. All three are career officers.

Surg. Gen. Burney stated that creation of the three new positions is consistent with the recommendations of the Study Group on the Public Health Service Mission, which urged a strengthening of the service's top administrative structure, "together with greater emphasis in leadership and coordination of the Service's increased activities in both environmental health

and in comprehensive health services in States and local communities."

PG course in basic metabolic problems

This course will be held in the auditorium of the School of Medicine, Louisiana State University, New Orleans, January 18 through 20, 1961, with headquarters at the Jung Hotel.

It is being presented by the American Diabetes Association in cooperation with the schools of medicine of Louisiana State University and Tulane University. Dr. T. S. Danowski, Pittsburgh, is chairman of the committee and director of the course, and Dr. Daniel W. Hayes, New Orleans, chairman of the local committee. Twenty-four distinguished teachers from throughout the country constitute the faculty.

The January 18 sessions will take up "Clinical Aspects of Lipids." The faculty will be Dr. Danowski, Dr. Edward H. Ahrens, Bethesda, Md., and Drs. Irving Graef, New York City; Marvin D. Siperstein, Dallas; Albert E. Renold, Boston; David Kritchevsky, Philadelphia; and Campbell Moses, Pittsburgh.

Other sessions will take up "Special Problems in Clinical Diabetes," "Seminars on Current Problems in Diabetes," "Diabetes as a Biological Spectrum: Pathogenesis and Manifestations," and "Tools for the Regulation of Diabetes Mellitus." The final afternoon will be devoted to "Syndromes Related to Diabetes Mellitus" and a clinical pathological conference.

The three-day course is open to physicians. The fee is $40 for members of the American Diabetes Association and $75 for nonmembers. The American Academy of General Practice will give 17 hours of Category II credit for the course.

Additional data and registration forms may be secured from the American Diabetes Association, 1E. 45th St., New York 17.

Federal grants for research in aging

Four Illinois institutions have received federal grants totaling $64,211 for research in various aspects of aging. This is part of 94 grants totaling $1,869,027 made to 29 states, Districts of Columbia, Canada, England, and Israel. Awards were made on recommendations to the Surgeon General by eight National Advisory Councils. The grants are part of a continuing National Institutes of Health program of study into the health-related characteristics of the aging process. Illinois grants are as follows:

University of Chicago, $15,327 for studies on pulmonary vascular resistance; and $16,939 for age norms and socialization in adulthood.

University of Illinois, College of Pharmacy, $12,351 for host-contaminant biology of certain diptera.

Roosevelt University, $8,197 for effects of early and late brain lesions on audition in the cat.

Northwestern University, $11,397 for physiological correlates of geophysical fluctuations.

PG course in ophthalmology

The Frank E. Bunts Educational Institute will present a postgraduate course in Newer Developments in Opthalmology December 7 and 8 in the North Clinic Building. Staff members of the affilated Cleveland Clinic Foundation will be assisted by several guest speakers: Victor A. Barnes, M.D., Brigadier General (USAF) Retired; Charles D. Regan, M.D., Boston; and C. Dwight Townes, M. D., Louisville.

The registration fee is $30.

1961 college film contest

The Committee on Motion Pictures of the American College of Chest Physicians is interested in learning about new films on diseases of the chest (heart and lungs) for possible presentation at its annual meeting in New York next June. Films accepted for presentation are eligible for the 1961 Film Contest. The committee is also interested in reviewing new motion pictures for inclusion in its approved film list.

Physicians are invited to forward all pertinent information concerning their films to Dr. Paul H. Holinger, Chairman, Committee on Motion Pictures, American College of Chest Physicians, 112 E. Chestnut St., Chicago 11.

Winners of the 1960 College Film Contest are:

First Prize: Michael E. DeBakey and George C. Morris, Jr., department of surgery, Baylor University College of Medicine, Houston,

"Fusiform Aneurysm of Aortic Arch, Resection and Replacement with Dacron Graft."

Special Award: United States Air Force, Robert B. Stonehill, Lt. Col., MC, USAF, technical advisor, Lackland Air Force Base, Texas, "Air Travel and the Cardiopulmonary Patient."

Honorable Mention: Chuzo Nagaishi, Tuberculosis Research Institute, Kyoto University, Kyoto, Japan, "Direct Intracavitary Insufflation with Chemotherapeutic Agent Using Metra's Catheter via Tracheo-Bronchial Route."

Honorable Mention: Theodore H. Neohren, University of Buffalo School of Medicine and Buffalo General Hospital, "Intermittent Positive Pressure Breathing (IPPB/I)—Its Clinical Application and Administration."

PG course in forensic pathology

A postgraduate short course, "Forensic Pathology," will be held at the Armed Forces Institute of Pathology, Washington, D. C., January 23-27. This course is designed to familiarize military and civilian pathologists with the problems of legal medicine and the role of the general pathologist in their solution. The material will be presented by specialists in the field of legal medicine through lectures and discussions, slide review, movies, and closed circuit TV. Applications from civilian physicians should be forwarded six weeks prior to the opening date of the course to the Director, Armed Forces Institute of Pathology, Washington 25, D.C.

Fund to train leaders in nursing

The National Fund for Graduate Nursing Education has been established to give graduate nursing education programs the urgently needed support to train teachers and leaders of bedside nurses.

A recent study by Columbia University revealed that masters degree programs in nursing cost the enrolling institution an average of $2,500, one third of which is met by tuition.

Less than 2 per cent or 7,000 of the 460,000 active nurses in the United States hold masters degrees to qualify them for teaching, administrative, or leadership positions. It is estimated that 60,000 nurse leaders are required for a nursing corps of 460,000. The 30 accredited graduate nursing education programs in 17 states and the District of Columbia grant masters degrees to 1,100 nurses per year; the need is four times that number. Illinois does not have an accredited graduate nursing program in its schools of nursing.

George F. Smith, president of Johnson & Johnson, is president of the fund. Headquarters is 280 Madison Avenue, New York 17.

Traineeships in radiation research

The Bowman Gray School of Medicine is beginning a training program in radiation biology and cancer related research. One, two, and three year traineeships at predoctoral and post-doctoral levels are being offered to research oriented persons in the basic and clinical sciences. Stipends range from $1,800 to $8,000.

It is believed that this training program represents an excellent opportunity for young men interested in research to learn radiation methodology and tracer techniques. The first year trainee will be expected to spend a good part of his time in the laboratory learning the techniques.

He will work with a preceptor or a group of preceptors. Second and third year trainees will be given the opportunity to do more advanced and independent research, employing radiation methods in his own chosen field of interest.

Applications are being accepted now for beginning in January of 1961, and will be accepted until April 15, 1961, to begin July 1, 1961. All inquiries may be directed to Donald J. Pizzarello, Executive Director, Radiation Biology and Cancer Related Research Training Program, Bowman Gray School of Medicine, Winston-Salem, N.C.

Medical history of war offered

Many of the medical lessons learned during World War I had to be relearned under fire during World War II because of paucity of distribution of the World War I medical history.

Lieut. Gen. Leonard D. Heaton, The Army Surgeon General, in an endeavor to prevent this costly relearning process, in the unhappy event of another war, has directed the publication and distribution of the "History of the Medical Department, United States Army, in World War II."

Of the 48 volumes programmed for the series, 15 have been published and can be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D.C. The set of 15 volumes may be purchased for $66.50; single volumes, from $3.50 to $6.25. Commanding officers of medical units may requisition copies for their Medical Units libraries by submitting DA Form 17 directly to the Historical Unit, U.S. Army Medical Service, Washington 12, D.C., ATTN: Promotion Branch.

Volumes now available and their editors or authors are:

"General Surgery," edited by Michael E. BeBakey, M.D.

"Neurosurgery," Volume I (Head Injuries), edited by R. Glen Spurling, M.D., and Barnes Woodhall, M.D.

"Neurosurgery," Volume II (Spinal Cord and Peripheral Nerve Injuries), edited by R. Glen Spurling, M.D., and Barnes Woodhall, M.D.

"Hand Surgery," edited by Sterling Bunnell, M. D.

"Ophthalmology and Otolaryngology," edited by M. Elliott Randolph, M.D., and Norton Canfield, M.D.

"Orthopedic Surgery, European Theater of Operations," edited by Mather Cleveland, M.D.

"Orthopedic Surgery, Mediterranean Theater of Operations," Oscar P. Hampton, M.D.

"Physiologic Effects of Wounds," edited by Fred W. Rankin, M.D., and Michael E. DeBakey, M.D.

"Vascular Surgery," edited by Daniel C. Elkin, M.D. and Michael E. DeBakey, M.D.

"Cold Injury, Ground Type," Tom F. Whayne and Michael E. DeBakey, M.D.

"Dental Service," George F. Jeffcott, D.M.D.

"Environmental Hygiene," James Stevens Simmons, M.D., and others.

"Personal Health Measures and Immunization," John E. Gordon, M.D., Tom F. Whayne, M.D., and others.

"Communicable Diseases," Volume IV, John E. Gordon, M.D., Joseph Stokes, M.D., and others.

"Hospitalization and Evacuation, Zone of Interior," Clarence McKittrick Smith.

Don't Forget to Mark Your Calendar for

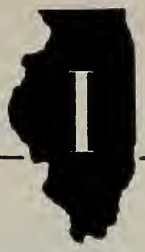
The 121st Annual Meeting of the

ILLINOIS STATE MEDICAL SOCIETY

at the Sherman Hotel, Chicago

May 14 through 18, 1961

NEWS of the STATE



County

Cook

HEADS HEART FUND DRIVE. Dr. Louis N. Katz, Chicago, director of the department of cardiovascular research at Michael Reese Hospital and a former president of the American and the Chicago Heart associations, has been appointed general campaign co-chairman of the 1961 Chicago Heart Fund Campaign.

Dr. Katz will help direct the drive for $1,350,000, an increase of $137,000 over last year, for further expanding the association's efforts directed at the control and prevention of heart disease.

HOSPITAL STAFF OFFICERS. The medical staff of the Sydney R. Forkosh Memorial Hospital at their first meeting of the 1960-61 year elected the following physicians as officers: Benjamin Dubrow, president; William E. Holtz, vice president; Fred Breiner, treasurer; Ralph Gradman, secretary.

ELECTED. Dr. Loyal Davis, professor and chairman of surgery in the Northwestern University Medical School, was named chairman of the regents of the American College of Surgeons for 1960-61 at their October meeting in San Francisco.

MEDICAL CAREER CONFERENCE. The University of Chicago held its second annual Medical Career Conference November 12. Promising students from 75 high schools in the Middle West, most of them from the Chicago area, attended.

Accompanied by 50 of their science teachers, they were shown 15 sets of demonstrations on basic science and clinical medicine. Fifty university doctors took part in the conference designed to help the students make decisions about their careers.

The group heard discussions: Dr. Lowell T. Coggeshall, vice president for medical affairs, on medicine on the national scene; Alan Simpson, dean of the college, on undergraduate education; and Dr. William R. Barclay on preparation for a career in medicine.

The students also witnessed an actual clinical pathological conference establishing a diagnosis of a difficult lung case.

DR. COGGESHALL RECEIVES AWARD. Dr. Lowell T. Coggeshall, vice president of the University of Chicago and professor of medicine, received the 1960 Pharmaceutical Manufacturers Association's Annual Award for outstanding basic contributions in medicine December 13 in New York.

Dr. Coggeshall's achievements range from attainment of an international reputation as an expert in tropical diseases to supervision of unprecedented expansion of the university's medical education, hospital, clinical, and research activities.

During World War II he served the military services in advisory and technical capacities, and more recently has held special posts with the federal departments of State and Health, Education and Welfare.

Dr. Coggeshall is a member of the Board of Health, chairman of the Citizens Advisory Committee to the Coroner of Cook County, and a member of the boards of directors of a number of medical and scientific institutions.

SERVICE LEAGUE'S CHRISTMAS PROGRAM. Service League Volunteers have brought the holiday spirit to paraplegics and many other patients at Chicago's Wesley Memorial Hospital through a program that keeps them busy making

something for themselves and their families. Patients turn out wreaths made with fir boughs, cones, fruit, and ribbons; Christmas stockings; lighted Christmas trees; and corsages made from their own bouquets or from cones and berries.



Patients and Volunteers at work on Christmas wreaths as part of the Service League's program.

Year-round projects include leather lacing and tooled billfolds, key cases, and mocasins; weaving and sewing; making dolls, baby bonnets, jewelry, and ceramics.

The Service League finances the program. It manages the hospital Gift Shop which, over the past two years, has provided $50,000 for research and $4,000 for arts and crafts.

Dr. Rothman Retires. Dr. Stephen Rothman, professor of dermatology and head of this section of the department of medicine at the University of Chicago since 1942, has retired.

As professor emeritus he will continue research work in Argonne Cancer Research Hospital, operated by the University of Chicago for the Atomic Energy Commission.

Dr. Rothman came to Chicago in 1938 from Budapest, where he had headed the dermatological and venereological out-patient clinic of the Institute for Social Medicine.

His volume "Physiology and Biochemistry of the Skin," published in 1954, is considered a classic in its field.

Among Dr. Rothman's basic research contributions are demonstrations of the mechanisms of autonomic cutaneous axon reflexes, studies of melanin pigmentation, and findings regarding screening action of para-aminobenzoic acid against sunburn.

He has served as chairman of the subcommittee on the cutaneous system of the Medical Research Division of the National Research Council and chairman of the Committee on Cosmetics of the American Medical Association, among many offices.

Society Passes Resolution on Foreign Internes and Residents. The South Chicago Branch of the Chicago Medical Society has taken cognizance of the plight of community hospitals where they believe the interne shortage has become acute and where the greatest number of patients are cared for. The situation had been alleviated to a degree by appointment as internes and residents graduates of foreign medical schools in the United States as exchange students under State Department programs. The society believes that their absence reduces the quality of medical care in the hospitals.

Therefore, the society has passed a resolution recommending that the present manner of selection of graduates of foreign medical schools to serve as internes and residents be reviewed. They further recommended that "the serious problems created by their absence from a great majority of our community hospitals should become a matter of intense interest and study to our medical societies at local, state, and national levels in order to bring about a satisfactory solution of this very critical and urgent problem."

Diabetes Association Awards Fellowships. Two new fellowships for research in diabetes and basic metabolic problems under an established investigator have been awarded by the American Diabetes Association. One of the recipients is Dr. John A. Colwell, Chicago. He will work with Dr. Arthur R. Colwell, Sr., in the department of medicine, Northwestern University Medical School, on the effects of various substances on insulin secretion in the unanesthetized dog.

The postdoctorate fellowships range from $4,500 to $6,500 a year.

Dr. Brody Opens Forest Hospital Program. Eugene B. Brody, M.D., opened the third annual Forest Hospital Scientific Program at Forest Hospital, Des Plaines, on October 26, with

a lecture on "The Freudian Theory of Psychosis: Implications for Therapy."

The entire 1960-61 program, consisting of once-a-month, Wednesday night lectures from 8-10 o'clock, October through June, will be devoted to "Therapy of the Schizophrenic." Admission is free and open to all professional persons.

The program through February is as follows:

Nov. 22—"The Prisoner's Dilemma and the Schizophrenic Family," Gregory Bateson, M. A., Stanford University.

Dec. 28—"Federn's Concepts and Their Applicability to the Understanding and Treatment of the Schizophrenic," Edoardo Weiss, M.D., Chicago.

Jan. 25—"Identity and the Therapy of Schizophrenia," Catherine L. Bacon, M.D., Temple University.

Feb. 22—"Outpatient Treatment of Borderline Schizophrenics: Handling of Emergencies," Melitta Schmideberg, M.D., New York.

Hospital Dedicates Research Building. Presbyterian St. Luke's Hospital's Jelke Memorial Building for medical science and research was dedicated November 2. It is named for the parents of John F. Jelke, Jr., retired Chicago manufacturer, who contributed $1 million toward its construction.

Nine floors have been completed, and six additional floors will be added when necessary funds are available. The third, fourth, fifth, and eighth floors will be occupied by laboratories; the sixth floor houses eight surgical operating facilities, bringing the hospital's total number of operating rooms to 25. The seventh floor contains surgical observation galleries and staff quarters. Mechanical equipment for the building is installed on the ninth floor. The first and second floors will become a part of new outpatient facilities when construction is completed.

Growth of Medicine Lectures. This series of lectures is being given by Northwestern University from January through March, 1961, from 8 to 9 a.m. in the Ward Building, Room 641. The program through February is as follows:

Jan. 11—"Medieval Medicine: Pre-Christian Fabric and Present-Day Remnants," Barry J. Anson, PhD., Rea Professor of Anatomy at the University.

Jan. 18—"Resolved; That the Hippocratic Oath be Revised," Max Samter, M.D., associate professor of medicine, University of Illinois College of Medicine.

Jan. 25—"The History of Gynecology," Abraham F. Lash, M.D., clinical professor of obstetrics and gynecology, University of Illinois College of Medicine.

Feb. 1—"Surveys of Medical Education," Richard H. Young, M.D., dean, Northwestern University Medical School.

Feb. 8—"Historical Developments of Medical Administrative Problems in the Hospitals," Mr. Kenath Hartman, superintendent, Wesley Memorial Hospital.

Feb. 15—"The Development of Our Knowledge of Penicillin," Robert C. Levy, M.D., assistant professor of Medicine, Northwestern University Medical School.

Feb. 22—"The History of Hemophilia with Special Reference to the Royal Families of Europe," Carroll Birch, M.D., professor of medicine, University of Illinois College of Medicine.

De Kalb

Dr. Carl Edward Clark, Sycamore, was named to serve a three-year term on the physician-advisory board of the American Association of Medical Assistants at their annual meeting in Dallas in October.

Kane

Newly elected officers of the Kane County Medical Society are Dr. H. W. Bruskewitz, Elgin, president; Dr. William K. Ball, Aurora, vice president; and Dr. Joseph L. Bordenave, Geneva, secretary-treasurer. They will be installed at the society's January 11 meeting at 6:30 p.m., Dunham Woods Riding Club.

Kankakee

Dr. Robert J. Ryan, assistant professor of medicine, chief of endocrinology, University of Illinois College of Medicine, spoke to the Kankakee County Medical Society on October 24 on "Thyroid Nodules."

Ogle

The Ogle County Medical Society has selected Dr. Robert M. Cager, Oregon, as president and Dr. Franklin D. Swan, also of Oregon, as secretary for the coming year.

Randolph

Dr. C. O. Boynton, Sparta, was recently honored with a parade and ceremonies commemorating him as the oldest physician in Randolph County. It was attended by Boynton babies ranging in age from 2 to 60. The 84 year old physician, who started practice in 1897 in a horse and buggy, again rode in one during the parade down Sparta's main street.

Vermilion

The Vermilion County Medical Society has approved use of the upper floor of the Tuberculosis Sanatorium in Danville for care of the aged, if it can be worked out on a simple basis. A letter was sent to the Commercial News refuting an editorial 10 days earlier that incorrectly stated the society was opposed to such use of the sanitorium.

Top Interest for TOPS. The meeting began at 9:15 p.m., and the enthusiastic audience, together with the speaker, was asked to leave two hours later by the janitor who had to close the building.

This is the measure of the interest in "Psychotherapeutic Approach to Dieting and Obesity," a lecture given by Dr. Angelo P. Creticos, Chicago, before 125 Debu-TOPS (Take Off Pounds Sensibly) in Skokie November 3.

The meeting was held in the Niles Administration Building. The 45 minute lecture was followed by a question and answer period brought to an end only by the city administration's ruling to close the building at 11 o'clock.

The lecture was arranged by the Committee on Postgraduate Medical Education and Scientific Service, Illinois State Medical Society.

Winnebago

Dr. J. Howard Maloney, who has practiced medicine in Rockford since 1914, was named in October the outstanding general practitioner in Winnebago County. The Bulletin of the Winnebago County Medical Society calls him a medical statesman of the highest order. He has been president of the county medical society, Illinois State Medical Society (1932), St. Anthony's Hospital staff, and the Winnebago County Tuberculosis Association. For many years he was on the state society's Committee on Postgraduate Education, was on the Board of Directors of the Illinois Hospital Service, and the Medical Surgical Service of Illinois, and has been medical director of the Rockford Municipal Sanitorium.

Dr. Maloney has been very active in Civic affairs also, and as a hobby cultivates roses. His friends and associates admire his great wit and humor retained over nearly 50 years of medical practice.

General

Appoint committee to implement Mills Bill

The Council of the Illinois State Medical Society has appointed an ad hoc committee to study the Kerr-Mills Bill and make recommendations for the state legislation necessary to implement it in Illinois.

The Mills Bill, passed by the present Congress, broadens the existing public assistance program to the aged (old age assistance) so that it includes the medically needy as well; that is, the aged who cannot meet the additional expense of medical care, if qualified, would receive assistance. The program will be known as medical assistance to the aged. By the terms of the bill federal matching funds will be made available to each state according to a set formula.

The state must, therefore, define the medically needy according to income and means, and must set up the benefits for single and married persons made eligible thereby.

Gov. Stratton has asked the Public Aid Commission to make a study and propose the needed legislation.

The Illinois State Medical Society, in the interests of its members, is endeavoring to work with the Commission in its advisory capacity. Members of the society's committee are Edward W. Cannady, East St. Louis, chairman; Richard J. Bennett, Chicago; Joseph W. Compton, East St. Louis; and Robert E. Heerens, Rockford.

Dr. Carnahan named Illinois GP for 1961

Dr. William Ernest Carnahan, 75, of Macomb, a McDonough County physician for 46 years, has been selected the Outstanding Illinois General Practitioner for 1961. Official presentation will be made at the Illinois State Medical Society annual meeting in Chicago next May. Dr. Carnahan is being honored for his ability as a physician, his kindnesses to his patients, his devotion to his community and country, and his long service to medicine.



Dr. William E. Carnahan

Following his graduation from the University of Illinois College of Medicine in 1914, he took up practice in Adair, serving a widespread rural area. Thirty-five years ago, Dr. Carnahan moved to Macomb, where in the practice of obstetrics he delivered more than 3,000 babies without a single maternal mortality.

In 1958 Dr. Carnahan was a moving spirit in the construction of the 110-bed McDonough District Hospital. He has attracted young physicians to follow in his footsteps and has joined with them in building a new clinic adjacent to the hospital.

He has served as chief of staff of McDonough and St. Francis hospitals and has been active in the McDonough County Medical Society. In 1957, he was honored as the Outstanding Citizen of Macomb, a town of more than 10,000.

Six years ago Dr. Carnahan was chosen to be the host to the foreign business and professional leaders who came to the United States under an international exchange program. Macomb was selected by the American Council on Education as a typical western farming community. He has seen that visitors from every continent have become acquainted with family, business, and professional life in a small community.

When Dr. Carnahan delivered a girl with a spinal tumor which caused complete paralysis from the waist down and threatened the child's sanity, he became her guardian. He refused to be discouraged by the opinions of numerous medical authorities that the case was hopeless. Learning that a Los Angeles surgeon had success in somewhat similar cases, Dr. Carnahan aroused local support and flew the girl, then 22 months old, to the Coast. Today, at eight, she has some use of her legs, gets around well with crutches, is a bright third grade student, an inspiration to all around her because of her cheery disposition, and the adopted child of a prominent family.

Dr. Carnahan is a member of numerous medical organizations, including the Illinois State Medical Society, American Medical Association, McDonough County Medical Society, Illinois Obstetrical and Gynecological Society, and Mississippi Valley Medical Association.

A member in the First United Presbyterian Church of Macomb, he served as an adult Bible class teacher for 20 years. Dr. Carnahan married Miss Lucy Heffner of Adair in 1913. They have a son, Lewis, who is with the American Council on Education in Washington, and a daughter, Eleanor, wife of Eric Downton, a London News war correspondent.

Illinois Fellows of ACS named

At closing ceremonies of the annual clinical congress of the American College of Surgeons, 46 physicians from Illinois were made Fellows. They have fulfilled comprehensive requirements for acceptable medical education and advanced training as specialists in one or another of the branches of surgery and have given evidence of good moral character and ethical practice.

Those receiving this distinction were:

Irvin H. Blumfield, Alton; Eugene P. Mitchell

and John B. Moore, III, Benton; Edward A. Razim, Berwyn; John W. Frisch and Rita Walsh, Bloomington; Leopoldo R. de Alvare, Joseph S. Drabanski, Robert J. Freeark, James R. Hines, Robert W. Jamieson, Vincent J. LaRocca, Frederick A. Lloyd, Frank J. Milloy, Oscar J. Rosenzweig, Earl B. Sanborn, Jr., William Schumer, Richard A. Shapiro, and David E. Shoch, Chicago.

Loring L. Unger, Decatur; John E. Familaro, Chafick N. Mansour, John W. Tope, III, Elmwood Park; Philip H. Sheridan, Evanston; Joseph F. Hinkamp, Glenview; Adolphus W. Dunn, Capt., USN, Great Lakes; Frank R. Johnson, Hinsdale; Harvey D. Scott, Jr., Jacksonville; William G. Neilson, Kewanee; Martin Pepper, La Grange; Louis C. Arp, Jr., Thomas W. Carter, James P. Johnston, Moline; Bernard L. Abrams, Morton Grove; Frank A. Folk, Naperville; Kenneth T. Hubbard, Oak Park; Leo Pevsner, Palatine; Gerald J. Schwab, Peoria; Arthur D. Poppens, Princeton; Antonin J. Troup, Quincy; Edward B. Schnell, Rockford; Henry E. Wolfe, Jr., Urbana; Donald P. Davis, Harry R. Freeman, Westchester; William, E. Hill, Wheaton; Robert D. Simpson, Woodstock.

Dr. Holinger gives Semon Lecture

Dr. Paul H. Holinger, attending bronochoesophagologist at Presbyterian-St. Luke's and Children's Memorial hospitals, gave the annual Semon Lecture at the University of London at the invitation of the joint committee of the University of London and the Royal Society of Medicine.

Only two other United States physicians have been invited to deliver the lecture since it was instituted in 1911 to honor Sir Felix Semon, an internationally known otolaryngologist at the university. The lecture preceded the meeting of the laryngological section of the Royal Society of Medicine on November 3.

Rockford Blue Shield reduces rates

Effective Dec. 1, 1960, Blue Shield rates to subscribers for the $200 and $300 Series were, reduced up to 20.5 per cent, according to Robert E. Whitsitt, M. D., president of the Blue Shield Plan with headquarters at Rockford. Dr. Whitsitt stated that the Department of Insurance has approved the rate reductions which will be beneficial to the subscribers of the programs.

This reduction in subscriber fees has been brought about primarily because of the cooperation of subscribers and physicians in not overutilizing the benefits available, and through good underwriting and low operating expense. The availability of benefits without hospital admission has been a determining factor in making this rate reduction possible.

At the same time, an addition to the benefits will be certain oral surgery procedures, heretofore not covered. Benefits under the Series $200 and $300 certificates include liberal surgical benefits for procedures in the hospital, in the doctor's office or clinic, in hospital medical visits (70 days per contract year), x-ray examinations in the hospital or doctor's office, radiation therapy and radioactive isotope, surgical assistants, intensive medical care, and the administration of anesthetic. Mr. Clark stated that the $200 Standard Certificate for single persons would be reduced as much as 11.7 per cent and family 20.5 per cent.

The Blue Shield Plan — Medical-Surgical Service of Illinois — with the home office at Rockford, serves 92 counties in the State of Illinois with offices in East St. Louis, Alton, Springfield, and Champaign.

Dr. Hodges opens ICS lecture season

The 1960-61 season's series of lectures for the International College of Surgeons was opened October 18 by Dr. Paul C. Hodges, emeritus professor and chairman, department of radiology, University of Chicago, with a talk on "Medicine Behind the Iron Curtain."

Dr. Hodges, who recently returned from Russia and Free China, pointed out that Russia provides more than 2,000 sanatoriums with facilities available for almost 3,000,000 patients and 900 holiday homes housing about 160,000 guests. Ownership is divided among central governments, provincial governments, trade unions, and farm groups.

He also noted excellent progress in corneal transplants as the famous Filatov Institute at Odessa, the eyes necessary to this operation being supplied by the undertakers without permission of relatives. In Moscow he recognized diagnos-

tic x-ray equipment of American and European design.

Medical care in Free China is slow and, apparently, he said, import restrictions do not permit progress. Modern equipment and properly trained technicians are required, especially in the radiological field. Dr. Hodges is succeeded there by a radiologist from the University of Chicago at Taiwan, Taipei, by permission of the China Medical Board. Its decision may provide additional visiting professors until the project is on a self sustaining basis.

Center for retarded children

Little City is the realization of the efforts of parents of retarded children and their friends. They accomplished this without state or federal funds. There are accommodations for 30 children, and as plans proceed there will be facilities for 30 more residents.

The original three buildings are cottages, one temporarily used for boys, one for girls, and the third for administrative purposes. Three other new buildings are nearing completion. Up to 25 cottages are anticipated for housing 15 to 17 residents each, except those for the specially handicapped.

Academic achievement testing has been conducted with each student to determine the present level of achievement and to assist in determining the direction of further training. The future plans include a school building to house eight classrooms, arts-crafts department, occupational-vocational training units, as well as necessary general educational equipment.

Medical facilities will include an infirmary with clinical and research buildings.

Dr. Paul heads heart association

Dr. Oglesby Paul, clinical associate professor of medicine at the University of Illinois College of Medicine, was installed as president at the annual meeting of the American Heart Association in St. Louis.

He has served on the AHA board of directors since 1956, as a vice president from 1957-59, and as chairman of the association's Council on Community Service and Education from 1957-60. He is vice president of the Chicago association, a member of its board of governors, and has served as secretary.

Currently he is directing a long-term health study at the medical school with a team of investigators, following a group of 2,100 men between the ages of 40 and 55. They are studying the role of various factors believed to play a part in the onset of certain diseases.

Crippled children clinics scheduled

Jan. 4—Aurora, Copley Memorial Hospital
Jan. 4—Hinsdale Sanitarium
Jan. 5—Flora, Clay County Hospital
Jan. 6—Chicago Heights (Cardiac), St. James Hospital
Jan. 10—East St. Louis, St. Mary's Hospital
Jan. 11—Champaign-Urbana, McKinley Hospital
Jan. 11—Joliet, Silver Cross Hospital
Jan. 12—Cairo, Public Health Building
Jan. 12—Springfield, St. John's Hospital
Jan. 17—Alton Memorial Hospital
Jan. 17—Danville, Lake View Hospital
Jan. 17—Peoria (Cerebral Palsy), Children's Hospital



Left: John, aged 17, shows his skill in repairing an electric clock. Center: Three of the girls relaxing in their attractive cottage. Right: Retarded girls enjoy learning good grooming habits too.

Jan. 17—Quincy, St. Mary's Hospital
Jan. 18—Evergreen Park, Little Company of Mary Hospital
Jan. 19—Decatur, Decatur-Macon County Hospital
Jan. 19—Elmhurst (Cardiac), Memorial Hospital of DuPage County
Jan. 19—Rockford, Rockford Memorial Hospital
Jan. 24—Peoria, Children's Hospital
Jan. 25—Centralia, St. Mary's Hospital
Jan. 26—Effingham (Rheumatic Fever), St. Anthony's Memorial Hospital
Jan. 26—Mt. Vernon, Masonic Temple
Jan. 26—Sterling, Community General Hospital

G P's elect officers

The Illinois Academy of General Practice at the annual meeting in September installed Dr. J. G. Gustafson, Moline, as president, and elected Dr. Maynard Shapiro, Chicago, as president elect. Dr. Harry Nesmith, Salem, was elected vice president and Dr. Lloyd Kiser, Champaign, was named a director.

Deaths

Paul L. Bergstrom*, Kirkland, a graduate of the School of Medicine of the University of Chicago in 1937, died October 10, aged 49. Dr. Bergstrom served for several years on the board of St. Mary's Hospital in Kirkland. He was chief surgeon on the USS Niobrara in World War II.

Byron B. Black, Chicago, a graduate of Loyola University School of Medicine in 1916, died October 7, aged 70. He had been a Chicago physician for 45 years.

Thaddeus J. Chrzan*, Chicago, a graduate of the Chicago Medical School in 1942, died October 15, aged 50. Dr. Chrzan had been a pharmacist before entering medicine and had served in the Army medical department in World War II. He was on the staff of Belmont Community Hospital.

Bertram C. Cushway*, Chicago, a graduate of the Northwestern University Medical School in 1903, died October 13, aged 78. Dr. Cushway, a radiologist, was past president of the Chicago Roentgen Society and a diplomate of the American Board of Radiology. He served on the staff, of St. Bernard, St George, Englewood and Evangelical hospitals. He was a member of the 50-Year Club of the Illinois State Medical Society.

Francis A. Dulak*, Chicago, retired, a graduate of the Chicago College of Medicine and Surgery in 1916, died October 24, aged 69. He did postgraduate work at the University of Vienna from 1921 to 1923, specializing in diseases of the eye, ear, nose and throat. Dr. Dulak had been secretary of the Chicago Board of Health since 1938 and a member of the board since 1934. He served on the Loyola University faculty for 19 years, attaining the rank of associate professor. He was a member of the executive board of St. Elizabeth's Hospital, where he had been a staff member for many years. He was also on the staff of Cook County Hospital for 19 years. Dr. Dulak was chief medical examiner of the North American & Polish National Alliance and was trustee of the AFL Union Health Service for 14 years. He had retired from active practice in 1952 when he became afflicted with a heart ailment.

Harvey William Garrison*, Williamsville, a graduate of the Chicago Medical School in 1950, died October 2, aged 49. Dr. Garrison was on the staff of both Memorial and St. John's hospitals in Springfield. He was a member of the Sangamon County Medical Society and the American Academy of General Practice.

Otto Hauser*, Mount Olive, retired, a graduate of the Missouri Medical College, St. Louis, in 1899, died July 29, aged 87. He was a member of the 50-Year Club of the Illinois State Medical Society.

Casimir F. Przypyszny*, Chicago, a graduate of the University of Illinois College of Medicine in 1922, died October 8, aged 63. He was a senior staff surgeon at St. Mary of Nazareth Hospital and a member of the International College of Surgeons and the Polish Medical Society.

Sheppard Remington*, Chicago, a graduate of Bennett Medical College, Loyola University School of Medicine, in 1915, died October 8, aged 67. Dr. Remington was chief of the orthopedic staff at Edgewater Hospital and a visiting orthopedic surgeon at Henrotin Memorial Hospital. He served as a captain in the Army Medical Corps in World War I.

Albert J. Schoenberg*, Chicago, a graduate of the University of Illinois College of Medicine in 1899, died October 31, aged 92. He was formerly on the staffs of the Illinois Masonic, Augustana, and Evangelical Deaconess hospitals and for 30 years had been chief of staff of Deaconess Hospital, when he resigned in 1938. Dr. Schoenberg was an assistant at St. Mary's Hospital, Pueblo, Colo., from 1902 to 1904. From 1910 to 1918 he was an associate and clinical instructor in gynecology at the University of Illinois College of Medicine. He was a member of the American College of Surgeons.

Herman M. Sondel*, Chicago, a graduate of Loyola University School of Medicine in 1917, died October 30, aged 69.

Harmon L. Summiers*, Marion, a graduate of the St. Louis College of Physicians and Surgeons in 1912, died July 27, aged 78. He was on the staff of the Marion Memorial Hospital.

Walter Sherwood Taylor*, retired, Ashland, a graduate of the Washington University School of Medicine in 1899, died October 15, aged 87. A fellow physician and emeritus member of the Sangamon County Medical Society, he had practiced in Central Illinois for 57 years. He was a member of the 50-Year Club of the Illinois State Medical Society.

Richard Barrett Terry, Chicago, a graduate of the University of London Faculty of Medicine in 1938, died October 3, aged 46. Dr. Terry specialized in internal medicine and was an assistant professor of medicine at Northwestern University. He was a consultant in medicine at Cook County Hospital and a member of the staff at Passavant Memorial Hospital. Dr. Terry was born in England and was a member of the Royal College of Physicians. He was a lieutenant colonel in the British Army medical corps in World War II.

John M. Tindal*, retired, Chicago, a graduate of the Indiana University School of Medicine in 1929, died October 20, aged 62. A certified Ophthalmologist and Otolaryngologist, he had been on the staff of St. Luke's Hospital before its merger with Presbyterian Hospital. Dr. Tindal also taught in the eye department at the Illinois State Eye and Ear Infirmary and was on the staff of the Central Free Dispensary at Rush Medical College. He was a member of the College of Surgeons, the Chicago Ophthalmology Society, and the Aux Plains Medical Society.

William Walter Van Wormer, Chicago, a graduate of the St. Louis University School of Medicine in 1903, died July 12, aged 82. He had practiced in Girard and Springfield and was a veteran of World War I.

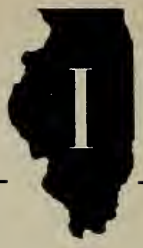
Bernard C. Walton, Marengo, a graduate of the Northwestern University Medical School in 1924, aged 68, was killed in an accident while cutting down trees at his home on October 9. He had practiced in Marengo since 1949.

James W. Wells*, Waltonville, a graduate of Barnes Medical College, St. Louis, in 1906, died October 5, aged 81. He was on the staff of Good Samaritan Hospital and was an advisor to the Jefferson County Department of Public Welfare. He was a member of the 50-Year Club of the Illinois State Medical Society and served in World War I with the Medical Corps.

Russel Perry Wells*, Pleasant Hill, a graduate of Barnes Medical College, St. Louis, in 1904, died October 3, aged 82. He had practiced medicine for 54 years and was a member of the 50-Year Club of the Illinois State Medical Society.

**Indicates member of the Illinois State Medical Society.*

BOOK REVIEWS



JEWISH MEDICAL ETHICS. Rabbi Dr. Immanuel Jakobovits. $6.00. Pp. 381. New York, Philosophical Library, 1959.

Summarizing the wisdom of 2,000 years, this excellent volume concerns itself with the teaching of the Old Testament, the Babylonian and Palestinian Talmud, and the rabbinical directives down to our times. The principal merit of Judaism lies in its emphasis on morality, on the unity of body and soul, and on preventive medicine. Its contributions to medicine are distinctive. From the earliest days it taught medical interference against disease, and it discouraged quackery, divination, sorcery, witchcraft, domination, soothsaying, necromancy, magic, consulting auguries, and ingesting human and animal excrement. It provided specific directions of primary importance in the fields of dietetics, purity of conjugal life, laws of eugenics and sexual conduct, rules on mental hygiene and behavior.

It enjoined the doctor to prolong the life of his patient to its fullest extent despite the length of life ahead. It adjured the physician to treat his patient as an individual, with kindliness and compassion, and to be understanding of the insane. It advised him to remove pain as thoroughly as possible in every case. It forbade him to do surgery on his own parents. It condoned postmortem examinations. It advocated dissolution of marriages childless after ten years. It condemned criminal abortion and upheld sterilization in male or female on medical indication. It insisted that the doctor be certified to practice his art, and that his conduct be one to meet the highest respect of his people.

The author inveighs against the present-day deterioration of our ethical values, a threat that our materialism imposes upon modern medicine itself.

He reminds us that we are living in an age that is rapidly forgetting what previous centuries have struggled to learn: that the best of medication is the acquisition of moral virtues, a dictum of Maimonides.

Frederick Stenn, M.D.

DISEASES OF THE NEWBORN. Alexander J. Schaffer, M.D., and Milton Markowitz, M.D. $20.00. Pp. 878. Philadelphia, W. B. Saunders Company, 1960.

This book is a comprehensive treatise of the normal and abnormal problems of the newborn period. The author has coined the word "neonatology" for the study of this short, rapidly changing, and dangerous time of life.

After a general introductory discussion of normals, variations of normals and abnormals, the various disorders of the newborn are described in more detail under major systems.

Under disorders of the respiratory system a section is devoted to the massive aspiration syndrome. This terminology reflects a practical application of wide clinical experience and close observation of the newborn. The etiology of respiratory distress is frequently obscure, and massive aspiration is a logical assumption as the cause of specific findings such as atelectasis, emphysema, pneumonia, or pneumothorax.

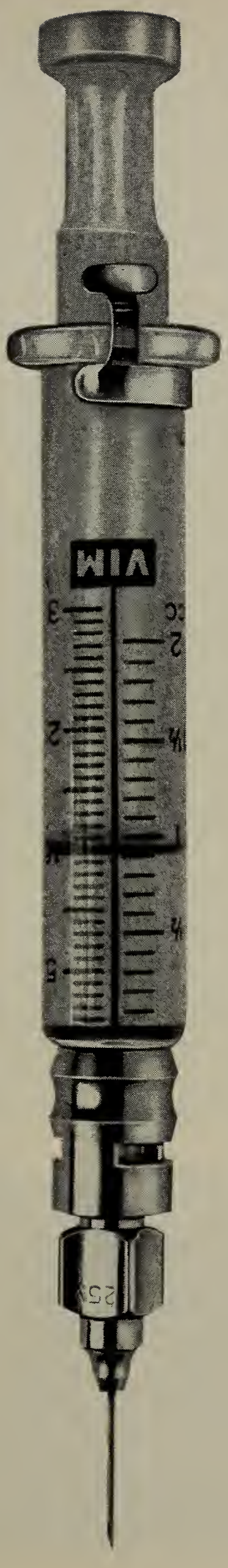
New unproven and involved forms of treatment for various clinical entities are reviewed. The application of vigorous therapy, although helpful but unproven, should be well seasoned with caution and wide experience.

Considerable space is devoted to cardiovascular disturbances. The incidence of emergency cardiac problems in the average nursery or neonate, however, is much less than the occurrence of difficulties arising from hemolytic disease.

Physicians, residents, and students will find this an excellent reference book when dealing with the common and unusual problems of the newborn infant.

L. Martin Hardy, M.D.

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Know the difference

It is dismaying to find that such simple terms as "private" and "public" ownership are not clearly understood by the American people. Even more so is the unfavorable connotation attached to "private" ownership by those who think they understand it.

A recent exhaustive survey of customers of investor-owned electric utilities discloses that a majority of Americans regard private ownership as something restricted to a favored few. On the other hand, they think public ownership means not statism suppression of individual rights, but something that is "available for everyone."

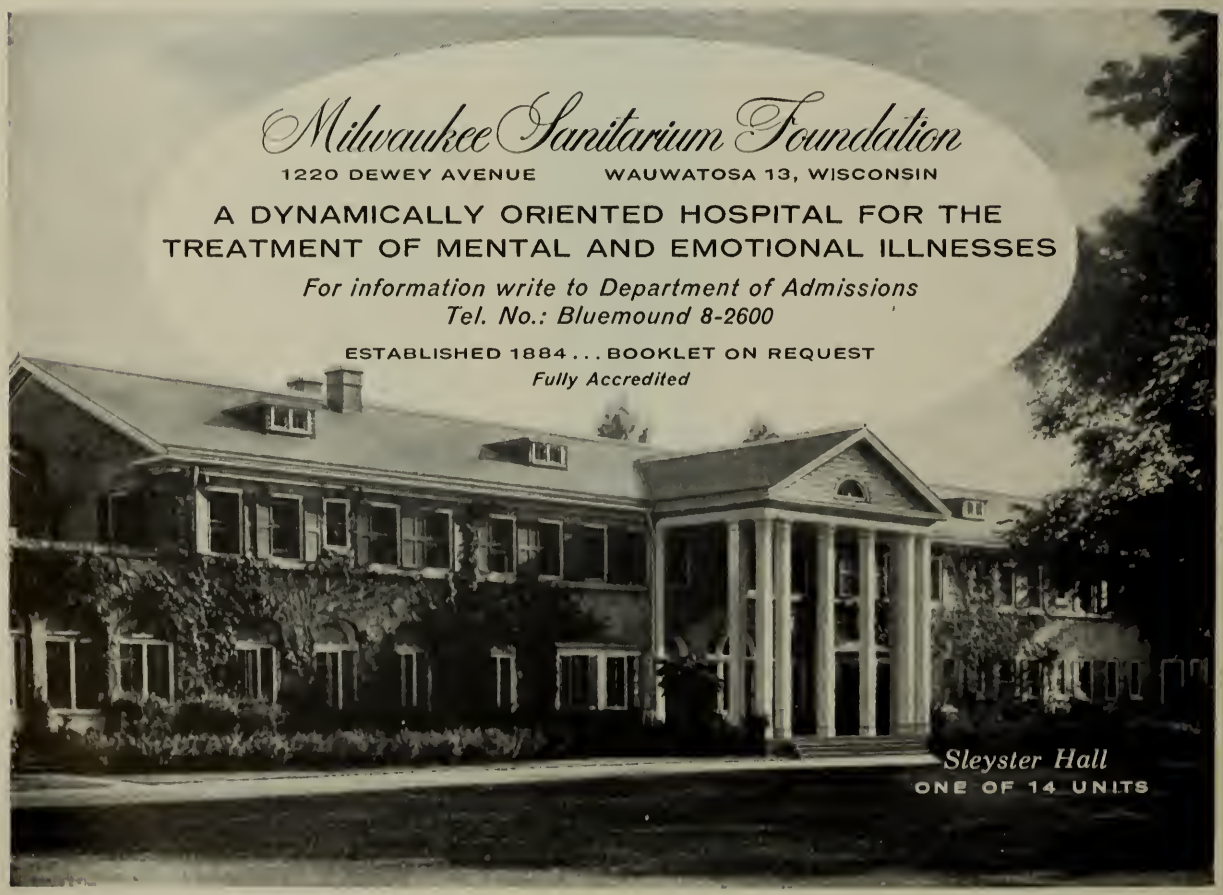
This confusion extends on through words which seem even more explict in their meaning. Less than half of those surveyed grasp the meaning of 'nationalized.' Nor is the term 'socialized' clearly understood.

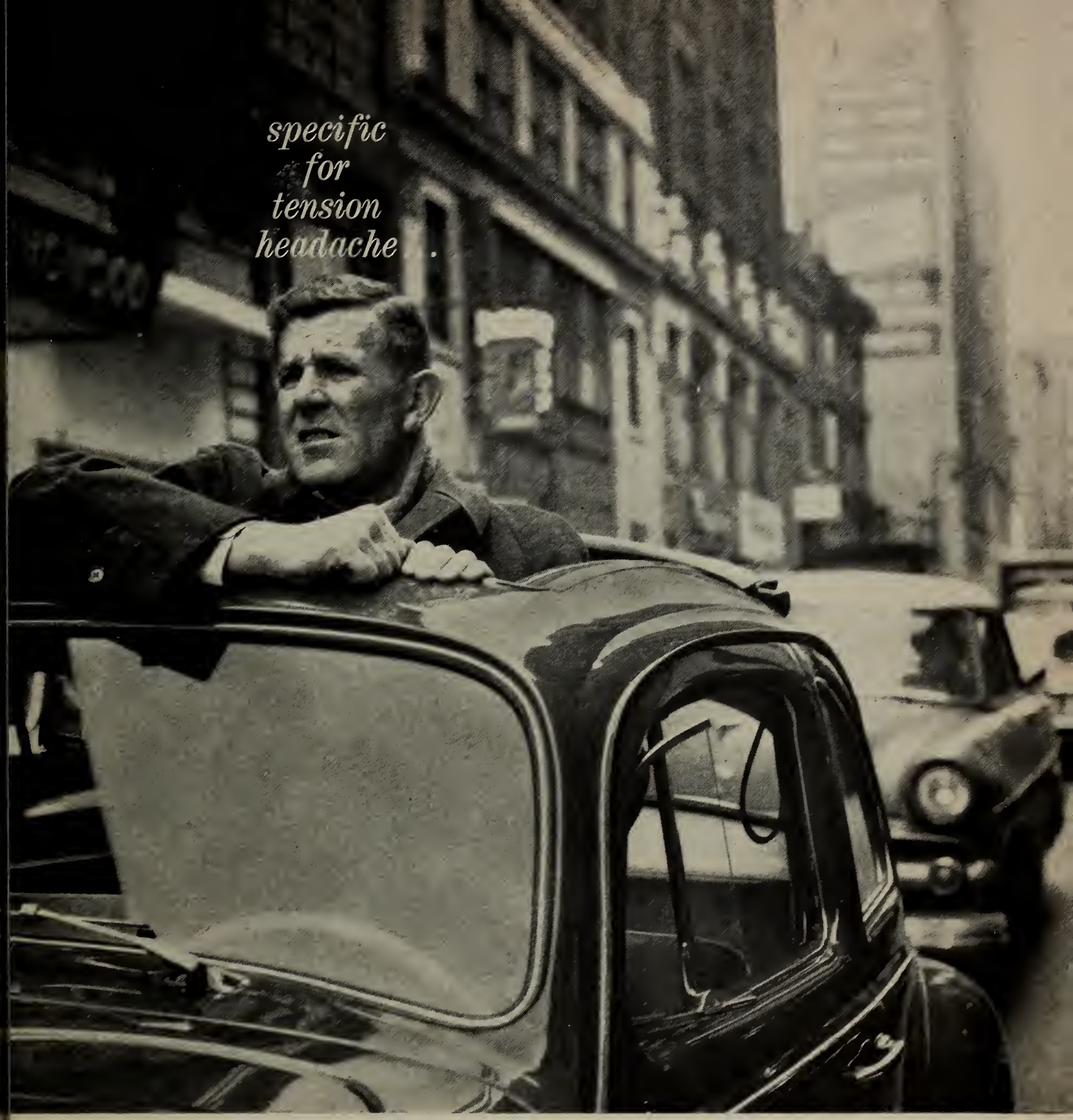
It may be that the unfavorable meaning attached to private ownership is a hangover from the long-gone days of the "robber barons" and "monopolists." Yet it is hard to see how anyone can fail to be aware that private ownership is the foundation of free enterprise, and has brought incalculable benefits to the nation.

Just to keep the record straight: Private ownership means ownership by private individuals, as opposed to government ownership, whether that ownership is vested in one person, or in hundreds of thousands of owners, as in the case of great corporations. Public ownership is government ownership, and government ownership is the first step on the road to Socialism. *Reprinted from Indianapolis News in Industrial News Review. Oct. 17, 1960.*

The physician and dental surgery

The best dental care is provided when a physician performs the presurgical physical examination. The public will demand this, particularly in the hospital setting. This is not discrimination against the dentist because often there are restrictions placed on general practitioners or on other specialities in much the same manner. *Mark Berke and Sidney Epstein, D.D.S. Dentistry in the Hospital. Hospitals Jan. 16, 1960.*





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Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

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Kidney homotransplant successful

Merrill and his co-workers now report a case of chronic glomerulonephritis with uraemia in which they successfully transplanted a kidney from a twin brother whose non-identity was demonstrated by his rejecting a skin graft from the patient. An unusally close antigenic relationship was nevertheless indicated by the slowness with which the healthy twin rejected the first skin graft (a second graft was rejected rapidly) and by consanguinity in no less than 25 blood-groups tested. The patient himself did not reject his twin's skin graft; but this was not considered evidence of identity, since skin homografts are known to survive exceptionally long in uraemic patients. In these somewhat unusual circumstances Merrill and his colleagues applied whole-body irradiation in low dosage (without marrow infusion) in the hope of averting the immediate antibody response that would otherwise be engendered by transplanting the healthy kidney. This operation was then successfully carried out and a functioning kidney established. A week later, when irradiation had reduced the white-blood-cell count to less than 50 per c.mm., the patient's critical condition prompted surgical exploration, which revealed an acute abscess involving the patient's own right kidney. This was drained and both his kidneys were removed. The spleen only was irradiated after the operation; and within a few weeks the patient's condition improved greatly: his white-blood-cell count rose, and his blood-pressure, heart size, and kidney function returned towards normal. Ten weeks after the operation he was discharged from hospital, and he has remained symptom-free and active for more than a year. Six months after its implantation the skin graft he had received showed slight atrophic changes, suggesting that it was undergoing very slow rejection. Biopsy of the transplanted kidney showed cellular changes with the same implication, despite good kidney function. This situation was met by repeated low-dose irradiation of the whole body, and by large doses of steriods—a combination which probably prevented a fatal homograft reaction. *Kidney Homotransplants in Man. Lancet. Sept.* 10, 1960.

Nothing so needs reforming as other people's habits. — *Mark Twain*

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Deep roots

Life Magazine recently devoted a full-page editorial to the thesis that this nation needs more, not less, toil. In the course of its discussion, it said: "Whether unions have too much power, that power is no longer directed toward the whole needs of the economy of the U.S. or the rest of the world. The enterpriser, the tax-reformer, the tariff-reducer can do a lot more to meet these needs than any of the current orthodox 'pro-labor' proposals such as a minimum wage hike which would increase unemployment by forcing employers to weed out workers who simply aren't worth more than $1 an hour."

If this seems a harsh judgement, it has deep roots in economic law. There is only one way that incomes can be increased and living standards improved without running the risks of disastrous inflation—and that is though increased worker productivity. The current minimum wage proposals are a good example of the wrong way to go about it. Not only would the wage be increased, but the law would be extended to millions of workers in local enterprises, notably retailing, who have hitherto been exempt. One result, as Life says, would be more unemployment—the affected enterprises would hire as few marginal workers as possible. A second result, in all likelihood, would be a new wave of price increases—that is, a new wave of inflation. A third result, which is directly tied in with the first, would be to deprive great numbers of unskilled people of the opportunity to gain experience that would qualify them for better jobs.

The biggest current need in the labor-management field is for programs designed to secure maximum production at minimum cost, within the limits of fair and reasonable work-weeks and work-rules. *Deep Roots. Industrial News Review. Oct.* 17, 1960.

Every tomorrow has two handles. We can take hold of it with the handle of anxiety or the handle of faith. We should live for the future, and yet should find our life in the fidelities of the present; the last is only the method of the first. — *Henry Ward Beecher*



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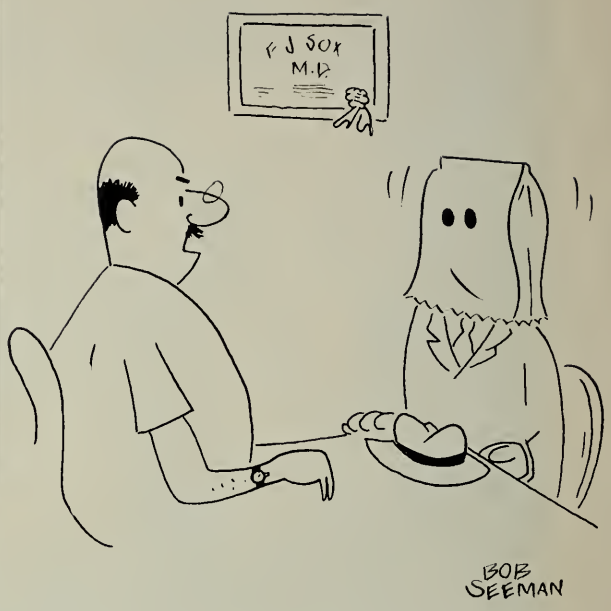
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Planning disaster medical care

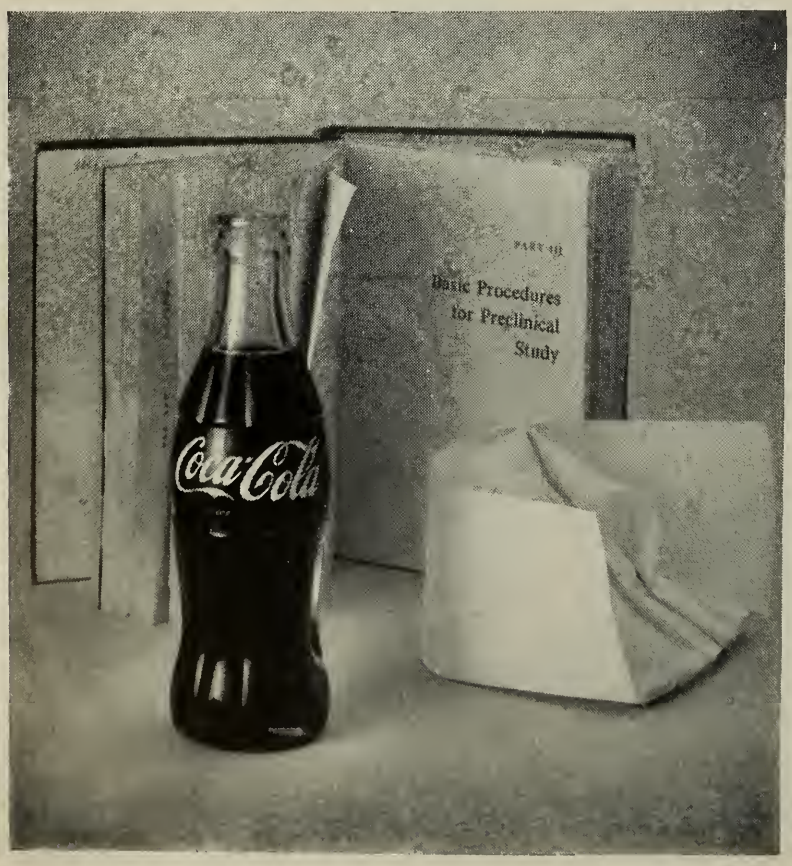
As to the organization of a county medical society for medical care in event of disaster, I must emphasize that there can be no effective disaster medical care without the participation in and the planning for such care by practicing physicians. The work of planning and the direction of such care must be the duty of the physicians' representative body—namely, the county medical society.

The organization of a county medical society for disaster medical care must begin with the appointment of a committee on disaster medical care. Physicians selected for this committee should have either executive organizational ability, a background in traumatic medicine, or field combat experience in World War II or Korea. *Wayne P. Chesbro, M.D. Disaster Medical Care, The Objectives of the A.M.A. Committee and the Organization of a County Society Program. California Med. August* 1960.

You cannot antagonize and influence at the same time. — *J. S. Knox*



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Kestler reports in J.A.M.A. (April 30, 1960) that conventionally treated low-back syndrome patients required an average of 41 days for full recovery (range: 3 to 90 days). The addition of Soma therapy in this comparative investigation reduced the average to 11.5 days (range: 2 to 21 days). With Soma, patients averaged full recovery 30 days sooner.

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Massive lymphedema

Some years ago the fact that the lymphatics of the red muscle are not blocked and there are no lumphatics in the epidermis suggested to us a possible treatment. If the epidermis could be applied to the muscle in thin enough layers, with excision of all the tissue which contained lymphedema, improvement might be effected in an extremity.

This treatment depends upon removal of the skin in such thin layers as to be above the lymph strata. Biopsies have shown that lymph accumulates in the dermis at the depth of 1/50 inch. The operation consists in taking off the epidermis with an electric dermatome at 15/1000 inch layers, so that no lymphatic-bearing epidermis or dermis is included. The rest of the dermis, subcutaneous tissue, fat, deep fascia, and all the fat between the muscles are then surgically excised. The epithelium is then sutured directly back onto the red muscle. In patients in whom all the fat, fascia, and lymph tissue have been removed completely lymphedema does not return. This is a radical and extensive operation and is, therefore, reserved for those patients in whom the monstrosity of the lymphedema and its complications require such a procedure. *Curtis P. Artz, M.D., and James D. Hardy, M.D. Massive Lymhpedema. Complications in Surgery and Their Management. W.B. Saunders Company.* 1960.

Supersonic aircraft noise

Those who live near airports are already martyrs to the noise which seems inseparable from flying. The supersonic airliner is not likely to bring any relief in these areas, but it may make the rest of us a good deal more sympathetic. Unless the aircraft stays below the speed of sound until it is near the top of its initial climb, a loud and continuous sonic boom will sweep the countryside over which it flies. It is perhaps as well that most of the flight path is likely to be over the sea. Inside the cabin, the noise level will be very high unless exceptional measures are taken to insulate the walls. *Supersonic and Hypersonic. Lancet Sept.* 10, 1960.

The price of wisdom is eternal thought.
—*Frank Birch*

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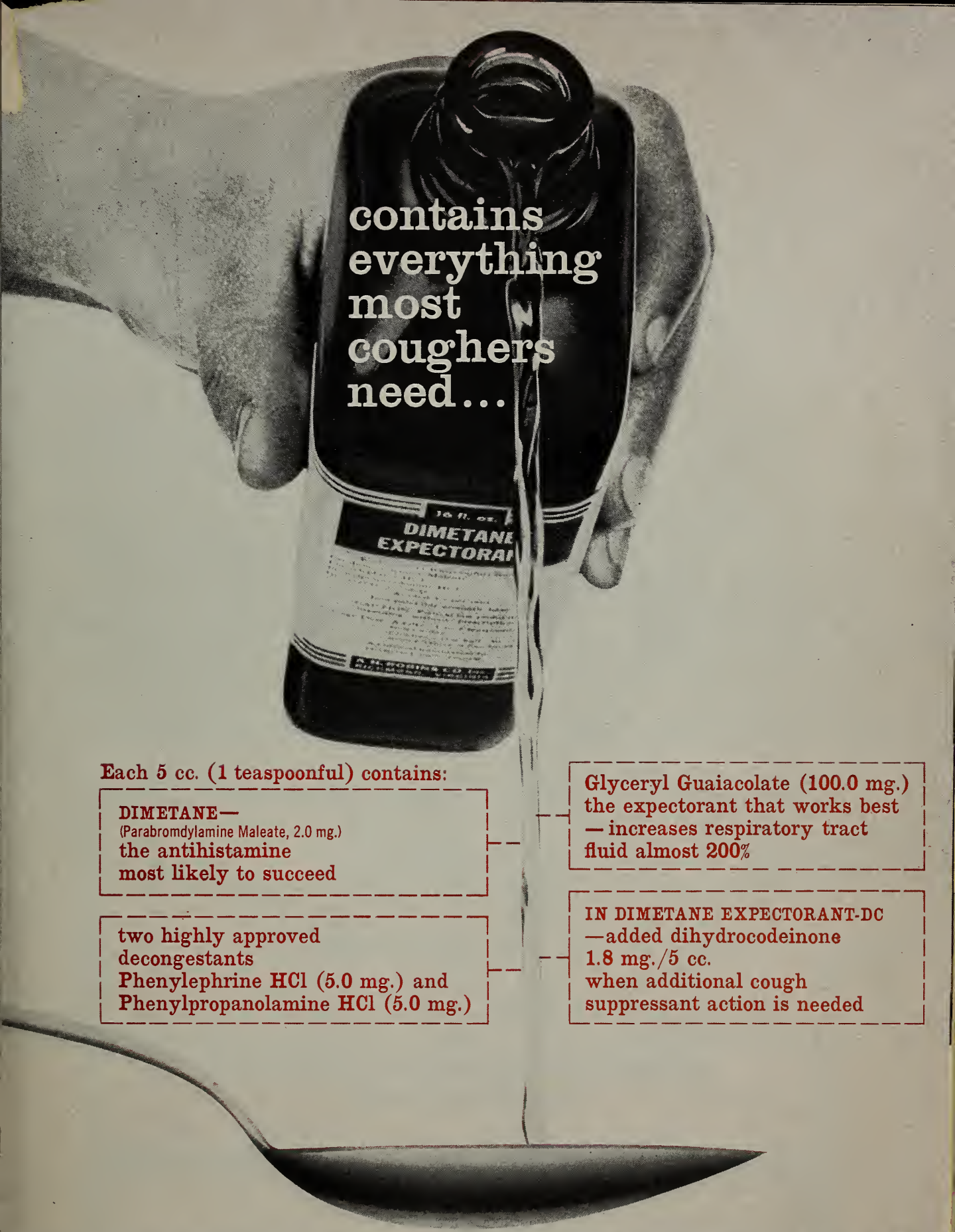
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Orthostatic proteinuria

The relationship of the proteinuria to posture was first noticed in 1904 and was described quite clearly by the investigators of that time, who had observed that this proteinuria would disappear completely when the individual was lying recumbent, that the proteinuria developed maximally when the individual maintained an erect lordotic position, and that the lordotic posture, even in the supine position, could induce proteinuria. Jehle reported one young girl who had proteinuria in the morning before arising from bed, and this was a puzzle until they learned that she combed her hair in bed every morning before getting up. This sufficiently involved her in the lordotic posture to cause proteinuria. When someone else combed her hair for her in the morning the proteinuria disappeared. Although the relationship to posture was early recognized, just how posture affected the proteinuria was not clearly understood, I think, until Dr. Bull's fairly recent study.

As mentioned, Dr. Bull has made interesting and illuminating observations on this condition. He also noted the effect of the erect lordotic posture on the proteinuria and showed by catheterization of the ureters that protein was present in the urine from both kidneys. He also found that the renal clearances in these patients were normal if they were recumbent, but if they were upright the filtration rate and the renal blood flow might fall considerably but did not fall to the same degree in patients who assumed the same position but did not develop proteinuria. In investigating this difference he measured the circulation time from foot to tongue and found again that in the patients who develop the orthostatic proteinuria the circulation time was much longer than in the control nonproteinuric subjects. Next he actually measured the venous pressure in the inferior vena cava by catheterization in some of these subjects and found that, although the pressure increased in anybody who went from the recumbent to the upright posture, the increase in pressure was much greater in those who showed the orthostatic proteinuria than in the controls. To correlate these observations he did some careful anatomic studies on specimens at postmortem and observed that the liver and the vena cava had a rather characteristic relationship at the site where the vena cava went up through the diaphragm. *Ralph C. Williams, M.D. The Medical Grand Rounds. Am. Pract. & Digest Treat. April 1960.*

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Many of us are like the little boy we met trudging along a country road with a cat-rifle over his shoulder. "What are you hunting, buddy?" we asked. "Dunno, sir, I ain't seen it yet."

—R. Lee Sharpe

Russian Party changes hamper scientists

A serious handicap for the Russian scientists in their research work is the ideological pattern on one hand and the instability of the Party line on the other. A sudden change in the Party line from above can cause a complete reorganization of plans and scientific units. Work has to be abandoned and sometimes new work begun. This happened for instance after the 1948 session of the Academy of Agricultural Sciences, when drastic Party-inspired changes caused complete reorganization of work in biological and related research and a purge of those scientists regarded as alien to the Party line. The Laboratory of Cytogenetics of the Institute of Cytology, Histology, and Embryology was abolished because it followed an "incorrect" and unscientific" line. The Bureau of the Division of Biological Sciences of the Academy of Sciences was assigned the task of revising the syllabus in biological institutes, bearing in mind the interest of Michurinism.

Another sweeping reorganization took place after the joint session of the Academy of Sciences and the AMS on the teachings of Pavlov in 1950, causing a change in topics and methods of research plans, as stated at the seventh session of the AMS in 1952:

A fundamental change occurred in the theory and practice of Soviet medicine. The basic theoretical premises, the general direction, and methods of research correspond now in most cases to the basic principles of Pavlov's teachings. . . . .The reorganization has found concrete forms first of all in the change of range of problems and topics of the institutes and laboratories. The main problem in scientific research is now the study of physiology and pathology of the higher nervous system. . . . .Such reorganization . . . required a change in structure of basic institutes of the Academy. *Background of Medical Research in the U.S.S.R. Academy of Medical Sciences of the USSR. July 20, 1960.*

Whatever you are by nature, keep to it; never desert your own line of talent. Be what nature intended you for, and you will succeed; be anything else and you will be ten thousand times worse than nothing.

—Sydney Smith

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